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ABSTRACT

As an introduction to a series on the array of issues in the implementation and evaluation of substance abuse prevention programs, this volume attempts to integrate two types of competence for alcohol and other drug abuse prevention program practitioners: program evaluation competence and cultural competence. The chapters in this document provide conceptual frameworks and practical suggestions for evaluators working with various ethnic groups. The chapter titles and authors are: (1) "The Challenge of Evaluating Community-Based Prevention Programs: A Cross-Cultural Perspective" (M. A. Orlandi); (2) "Of Kindred Minds: The Ties that Bind" (J. P. Butler); (3) "Practical Considerations for Program Professionals and Evaluators Working with African-American Communities" (C. A. Grace); (4) "A Culturally Sensitive Model for Evaluating Alcohol and Other Drug Abuse Prevention Programs: A Hispanic Perspective" (J. M. Casas); (5) "Hispanics: What the Culturally Informed Evaluator Needs To Know" (A. M. Padilla and V. N. Salgado de Snyder); (6) "American Indians and Alaska Natives: Changing Societies Past and Present" (C. M. Fleming); (7) "The Role of the Researcher in Evaluating American Indian Alcohol and Other Drug Abuse Prevention Programs" (F. Beauvais and J. E. Trimble); (8) "Cultural Competence for Evaluators Working with Asian-American Communities: Some Practical Considerations" (S. Kim, J. H. McLeod, and C. Shantzis); (9) "Cultural Competence for Evaluators Working with Asian/Pacific Island-American Communities: Some Common Themes and Important Implications" (S. Yen); and (10) "Defining Cultural Competence: An Organizing Framework" (M. A. Orlandi). (SLD)

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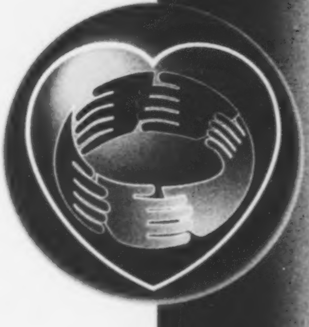
Office for Substance Abuse Prevention

OSAP Cultural Competence Series

Drug-Free Communities by the Year 2000



Cultural Competence for Evaluators

A Guide for Alcohol and Other Drug Abuse Prevention Practitioners Working With Ethnic/Racial Communities

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

OSAP Cultural Competence Series I

Cultural Competence for Evaluators

A Guide for Alcohol and Other Drug Abuse Prevention Practitioners Working With Ethnic/Racial Communities

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The primary objective of the Office for Substance Abuse Prevention (OSAP) Cultural Competence Series is to promote the development and dissemination of a scientific knowledge base that assists prevention program evaluators and practitioners in working with multicultural communities.

OSAP supports the rigorous evaluation of demonstration programs designed to promote health and prevent alcohol and other drug (AOD) problems for all people. All positions taken on specific approaches to evaluating AOD abuse prevention programs are positions of the communities, prevention experts, and authors who contributed to this monograph and may not necessarily reflect the opinions, official policy, or position of OSAP; the Alcohol, Drug Abuse, and Mental Health Administration; the Public Health Service; or the U.S. Department of Health and Human Services. Other groups that developed and/or implemented specific methods for evaluating AOD abuse prevention programs are documented in the text of this monograph.

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Foreword

With *Cultural Competence for Evaluators: A Guide for Alcohol and Other Drug Abuse Prevention Practitioners Working With Ethnic/Racial Communities,* the Office for Substance Abuse Prevention (OSAP) introduces the first in a groundbreaking series of cultural competence publications. This volume examines the issue of cultural competence for program evaluators as it relates to African-American, Hispanic, American-Indian, Alaska-Native, and Asian/Pacific Islander-American community groups.

OSAP's Cultural Competence Series is designed to advance scientific study and evaluation of community alcohol and other drug (AOD) abuse prevention approaches within the multicultural context of the United States. Each of our multicultural communities offers a rich and diverse ethnic heritage that, if fully explored and understood, will play an important role in the development of AOD prevention programs that focus on strengthening cultural resiliency and protective factors.

Cultural Competence for Evaluators will increase understanding of America's diverse ethnic heritage, both its risk factors and the cultural factors that contribute to cultural resiliency. In doing so, it will enhance the knowledge and skills of AOD prevention program evaluators working with ethnic/racial communities.

The Cultural Competence Series provides OSAP with a great opportunity to formulate effective strategies for AOD professionals working in multicultural settings. This unprecedented volume will establish a framework for celebrating the diversity of our United States and the unity within that diversity. We hope that the knowledge contained in this monograph will stimulate new ideas and further prevention efforts among all Americans.

Elaine M. Johnson, Ph.D., Director
Office for Substance Abuse Prevention

Dedication

To the Unity hidden in diversity.

Glossary of Key Terms

Culture: The shared values, norms, traditions, customs, arts, history, folklore, and institutions of a group of people.

Cultural Competence: A set of academic and interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among, and between groups. This requires a willingness and ability to draw on community-based values, traditions, and customs and to work with knowledgeable persons of and from the community in developing focused interventions, communications, and other supports.

Cultural Diversity: Differences in race, ethnicity, language, nationality, or religion among various groups within a community, organization, or nation. A city is said to be culturally diverse if its residents include members of different groups.

Cultural Sensitivity: An awareness of the nuances of one's own and other cultures.

Culturally Appropriate: Demonstrating both sensitivity to cultural differences and similarities and effectiveness in using cultural symbols to communicate a message.

Ethnic: Belonging to a common group—often linked by race, nationality, and language—with a common cultural heritage and/or derivation.

Language: The form or pattern of speech—spoken or written—used by residents or descendants of a particular nation or geographic area or by any large body of people. Language can be formal or informal and includes dialect, idiomatic speech, and slang.

Mainstream: A term that is often used to describe the "general market," usually refers to a broad population that is primarily White and middle class.

Multicultural: Designed for or pertaining to two or more distinctive cultures.

Nationality: The country where a person lives and/or one that he or she identifies as a homeland.

Race: A socially defined population that is derived from distinguishable physical characteristics that are genetically transmitted.

Religion: A system of worship, traditions, and belief in a higher power or powers—often called God—that has evolved over time, linking people together in a commonality of reverence and devotion.

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The Challenge of Evaluating Community-Based Prevention Programs: A Cross-Cultural Perspective

Mario A. Orlandi, Ph.D., M.P.H.

Introduction

This volume represents the first in a series of publications sponsored by the Division of Community Prevention and Training of the Office for Substance Abuse Prevention (OSAP). The series seeks to analyze and synthesize the complex array of issues that arise when alcohol and other drug (AOD) abuse prevention programs are implemented and evaluated in settings that are ethnically and racially diverse.

As an introduction to the series as a whole, this first volume has as its goal the functional integration of two types of competence for AOD abuse prevention program practitioners: program evaluation competence and cultural competence. Its main objective is to enhance the knowledge base and skills of professionals who are responsible for evaluating AOD abuse prevention programs in ethnic/racial community settings. The authors worked together to develop complementary chapters that provide conceptual frameworks and practical suggestions for evaluators working with African-American, Hispanic, American-Indian/Alaska-Native, and Asian/Pacific Island-American population groups.

This unprecedented effort began in April 1990 with a working meeting conceptualized by OSAP's Division of Community Prevention and Training as a creative process through which the authors could collectively shape every aspect of their own contributions and the work as a whole. This working group collaborated on establishing guidelines that included the use of common terminology, agreement on target audience, deadlines, and review procedures. By using this approach, the authors were provided with a rare opportunity to have both an individual and a collective impact on all phases of the book's development.

This work's target audience includes primarily those individuals who participate in planning and implementing AOD program evaluations in both primary prevention and treatment settings. Such individuals may be members of either the research or practitioner communities, and it is assumed that they have received, or are in the process of receiving, basic training in program evaluation methodology. Thus, this text could serve as supplementary reading for basic training or continuing education courses in this area, or it could be used by individuals as a part of a self-study program.

Although the four pairs of chapters that deal with specific population subgroups were written as companion pieces, they can be read in any order that suits the reader's needs or interest. This first chapter provides some general background information that introduces the eight culture-specific chapters that follow. The final chapter refocuses on the issue of cultural competence and, drawing from the material that precedes it, develops a theoretical framework for defining and understanding this complex concept.

This first chapter has five main objectives: (1) to explore the relationships between culture and health within the context of social science theory; (2) to discuss AOD problems as public health challenges and to summarize the prevention approaches that have evolved as solutions to these problems; (3) to characterize program evaluation as a communication process with both scientific and artistic dimensions; (4) to distinguish between two areas of expertise—program evaluation competence and cultural competence—that need to be synthesized to address the challenge of effective AOD program evaluation in ethnic/racial communities; and (5) to offer a three-part approach for achieving such a synthesis that provides a rationale for the eight culture-specific chapters that follow and for the monograph series as a whole.

Culture and Health

For a full appreciation of the complex role that culture plays in the natural history and psychosocial development of AOD use behavior, it is first important to define the term *culture* within the context of personal and public health. Unfortunately, more than 200 definitions of culture have been compiled (Heath 1986), and there is little agreement on a commonly accepted or universal definition.

Linton (1947) defined *culture* as the customs, beliefs, values, knowledge, and skills that guide a people's behavior along shared paths. More recently, scholars have expanded this list of psychosocial signposts to include other constructs such as *social norms,* the shared rules that specify appropriate and inappropriate behavior (Berne 1964); *mores,* the norms that people consider vital to their well-being and to their most cherished values (Bellah et al. 1985, pp. 275–296); and *sanctions,* the socially imposed rewards and punishments that compel people to comply with norms (Light and Keller 1985, pp. 58–59).

Like other terms that are intended to synthesize many complex factors, culture loses much of its practical significance when defined either too narrowly or too broadly. Because comprehensive reviews of this topic have appeared elsewhere (Green 1982; Wright et al. 1983), this chapter will confine itself to identifying the aspects of culture specifically relevant to issues related to the evaluation of AOD programs.

Our operating definition of culture is the shared values, norms, traditions, customs, arts, history, folklore, and institutions of a group of people. Within this perspective and from this definition cultural competence is a set of academic and interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among, and between groups. This requires a willingness and ability to draw on community-based values, traditions, and customs and to work with knowledgeable persons of and from the community in developing focused interventions, communications, and other supports (OSAP 1992).

The uses of the term *culture* that are relevant to this monograph are embodied in the scientific perspective of social learning theory (Baudura 1986) and in its extrapolations to the various domains of health-related behavior (McAlister et al. 1982). This perspective maintains that human learning always occurs within a social context, and the endogenous characteristics of an individual, that individual's behavior, and the environment within which that behavior takes place are in a constant state of dynamic interaction referred to as *reciprocal determinism.*

As Baranowski (1990) has noted, this continuous interplay between the person, his or her behavior, and the environment is a significant departure from more static notions that the person alone (Hall and Lindzey 1970) or the environment alone (Winett and Ester 1982) determines behavior, as was thought in the past. Culture does not exert its influence at any particular point in this system of reciprocal determinism; it has a fundamental influence on each component as well as on how each interacts. For example, an ethnic/racial group's shared norms, beliefs, and expectations regarding alcohol and its effects shape not only the group members' drinking habits per se, but also the ways in which the members behave while drinking and their perceptions of personal and collective responsibility for the outcomes of drinking. In this way, both the endogenous characteristics of such a group and the behavioral manifestations of these characteristics are directly influenced by culture. Analogously and over time, as reciprocal determinism would indicate, a culture is in turn influenced by the characteristics of the group and its behaviors. Similarly, the environment in which behaviors occur is both a manifestation and a determinant of the cultures that compose it.

The influences that social learning theory and the principle of reciprocal determinism have had on our perceptions of health and illness are incalculable. Since the turn of the century, our society has witnessed a dramatic change in the primary causes of death and illness. The pattern has shifted from diseases that were primarily infectious, such as influenza and polio, to chronic diseases, such as cancer and heart disease (Wynder and Orlandi 1987). Because the primary causes of death today are health problems that are influenced directly by lifestyle decisions—for example, diet; exercise; and the consumption of alcohol, tobacco, and other drugs—the responsibility for maintaining health has shifted concomitantly from the health care system to the community and individuals within it.

The realization that diseases can be prevented and devastating health problems averted has, in turn, created the need for public health planning approaches that place far more emphasis on lifestyle reorientation and behavior change interventions than has been called for in the past (Farquhar 1978). During the past two decades, a social movement of major proportions has taken place, resulting in the development of such approaches. This movement evolved, first, from the knowledge that behavior and culture shape each other reciprocally and, second, from the realization that the major causes of death and illness are preventable through changes in collective and individual lifestyles (Public Health Service 1991*b*).

What distinguishes recent health promotion interventions from earlier public health initiatives are the following: First, greater emphasis has been placed on health enhancement and disease prevention through behavioral change rather than on medical (pharmacological or surgical) treatment. Second, expectations have increased regarding an individual's responsibility for his or her own health. And third, the notion of what constitutes an appropriate target for such interventions has broadened to include individuals, families, groups, organizations, institutions, political systems, and the environment as a whole (Preston et al. 1989).

Obviously, these distinguishing features of health promotion interventions are closely related to the three components of reciprocal determinism—the person, his or her behavior, and the environment; the parallel influences of cultural factors on such interventions are to be expected and have been discussed in detail elsewhere (Orlandi 1986, 1987). As a unifying theme, however, the health promotion approach has suggested specifically that societal problems related to alcohol and other drug use be tackled in a comprehensive manner, from multiple levels simultaneously rather than through efforts directed at certain groups or individuals on a piecemeal basis. The implications of this approach for the development of programs to prevent alcohol and other drug problems are further discussed later in this chapter.

Cultural Change and Cultural Semantics

As the foregoing suggests, cultures do not remain the same indefinitely. Cultural subgroups exert an influence over and are influenced by individuals who are members of those groups as well as other cultural groups with whom these subgroups come into contact. Consequently, cultures may evolve over time. An important dimension for cultural change, and one that is of great concern to African Americans, Hispanics, American Indians/Alaska Natives, and Asian/Pacific Island Americans in our society, is the degree to which these so-called subcultures become assimilated into the White Anglo-American mainstream culture.

The view that suggests that this process is inevitable, unidimensional, and unidirectional, resulting in the proverbial melting pot of culturally equivalent Americans, is called acculturation theory. According to this theory, as exposure to the mainstream culture persists, identification by ethnic/racial group members with their original cultural heritages diminishes. This theory has been challenged by Oetting and Beauvais (1990), who have noted that the degree of acculturation is not a significant predictor of alcohol and other drug use behaviors or of other behaviors it has tried to explain. These researchers have instead developed the orthogonal cultural identification theory, which maintains that an individual's cultural identification can best be described along a number of different dimensions that are independent of one another.

This allows for the possibility of cultural identification with more than one culture simultaneously, or *biculturalism*, and suggests that single-dimension explanations are too simplistic. This issue is a critical one that has been dealt with by each author in this monograph, although in somewhat different ways, as the following chapters will indicate.

Similarly, there are other terms used throughout this monograph that should be clarified at the outset. *Multicultural*, for example, is used here to distinguish settings, such as those found in many urban communities, where a number of different ethnic/racial cultures coexist. It is also used to describe AOD intervention programs or evaluation approaches that attempt to be relevant and salient to several different ethnic/racial cultures simultaneously.

The term *cross-cultural* also has particular relevance for the discussion in chapter 10. It refers to the communication process that ensues when individuals who are part of one culture interact with those from another in areas that are salient to cultural identification (Trimble 1991)—as, for example, when individuals who are part of the White Anglo-American mainstream culture evaluate AOD programs in ethnic/racial communities that are not part of that mainstream culture. This particular area is dealt with in more detail below.

Alcohol and Other Drug Abuse: Pervasive Problems and Possible Solutions

No domestic issue has more consistently or more dramatically captured the attention of the American public over the past decade than the so-called war on drugs (Gitlin 1990). Mass media references to problems created by alcohol, tobacco, and other drugs are ubiquitous (Gerbner 1990), and the current administration's focus on this issue has engendered a panoply of emotions among different segments of the population, varying from anger and fear to hope (Public Health Service 1991*a*).

Available epidemiological data suggest that drug abuse in the United States increased dramatically in the decades following the 1960s (Kozel and Adams 1986). A comparison of surveys conducted over this period reveals that, by the early 1970s, the percentage of the population who reported having had any experience with illicit drugs had doubled to over 10 percent from levels reported in the 1960s (Public Health Service 1991*a*, p. 14). By 1974, the percentage of young adults (those aged 18–25) who reported having tried illicit drugs rose to over 50 percent and it is estimated that by 1991, over 37 percent (75.4 million people) of all those over 12 years of age in America had experimented with these substances (NIDA 1991).

More recently, however, encouraging trends have been noted. For example, recent data indicate that lifetime prevalence among younger groups (those 12 years or younger) and current prevalence among all age groups have declined steadily since 1979. In fact, young people today are much less likely to use drugs of any kind than were their same age cohorts in 1979, and the National Household Survey on Drug Abuse has reported that current use of illicit drugs in the total population has decreased consistently in recent years, with notable reductions between the years 1985 and 1991 (NIDA 1991).

Despite these promising trends during the past decade, alcohol and other drug problems have continued to exact a heavy toll on our society and there continues to be cause for considerable concern. The High School Senior Survey, for example, reveals that the level of involvement that our Nation's students have with illicit drugs is higher than that of students in any other industrialized nation in the world (Johnston et al. 1991). This survey has also consistently shown that students who do not plan to continue their education beyond high school are more likely to use illicit drugs than are those students who do plan to continue.

Of relevance to the issues dealt with specifically in this monograph, members of ethnic/racial groups are disproportionately represented among those students who drop out of high school. Similarly, they are also disproportionately represented among abusers of heroin and other illicit drugs (Kozel and

Adams 1986; NIDA 1991). Although it has been consistently recognized that ethnic/racial population groups have been inadequately represented among the major AOD use prevalence studies conducted in the United States, available data from treatment programs and health care facilities indicate that these population groups are overrepresented among injected drug abusers and among those people treated for drug abuse-related illness (Public Health Service 1991*a*, p. 35).

Another clear indication of the importance that our Public Health Service has placed on enhancing efforts to control AOD problems is the emphasis this risk factor for poor health has been given in the national objectives for health promotion and disease prevention as presented in the report *Healthy People 2000* (Public Health Service 1991*b*). In this document, which is the clearest statement of national health policy available, AOD programs have been included among the priority areas targeted for enhanced health promotion efforts during the next decade. Also in this group, tobacco use control has been affirmed as significant by its inclusion as a separate priority area; and, of relevance to the discussion that follows, educational and community-based initiatives have been identified as a third priority area that bears directly on the focus of this monograph.

Prevention Strategies: Past, Present, and Future

Since the mid-1960s, in an attempt to respond to the growing concern over AOD problems in our society, various prevention initiatives have been conceptualized and implemented. These efforts have differed widely in both general strategy and specific focus. During the 1960s, for example, efforts were made in a variety of formats to inform and educate the public regarding the negative aspects of AOD use, misuse, and abuse. Some of these campaigns, in addition to providing information, tried to arouse fear among potential young AOD users in the hope that this would effectively deter experimentation and decrease abuse. Although these efforts had some effect on AOD knowledge levels and on attitudes regarding AOD use, they had essentially no effect on AOD use, misuse, and abuse behaviors (Schinke and Gilchrist 1985).

During the 1970s, the emphasis shifted to what were termed affective education approaches: efforts designed to influence the attitudinal and psychosocial variables that were believed to be causally linked to the prevention of AOD use behavior. These variables include self-efficacy, self-esteem, and several other factors related to positive attitudes, values, and beliefs (McAlister 1983). These programs were similarly ineffective in producing meaningful changes in AOD use; however, they did point the way to other approaches that were somewhat more promising.

During the late 1970s and throughout the 1980s, combinations of psychosocial skills and life skills interventions were developed and tested as primary prevention approaches for AOD use among youth. Intended primarily as school-based initiatives, these programs have demonstrated modest success in reducing tobacco use despite significant administrative and logistical barriers that must be overcome during their implementation (Botvin and Tortu 1988). The recognized shortcoming of such approaches, however, has been their inability to sustain intervention effects over any appreciable length of time (Moskowitz 1989). The most probable explanation for this is that interventions that focus their positive influence on one specific context or element of an individual's life—for example, the school context for adolescents—will eventually fail if the summative effects of all other negative influences are greater. Thus, given that students spend a relatively small portion of their time in school, the role of family, friends, organizations, groups, mass media, and other nonschool influences should not be ignored.

This realization has led to the development of prevention efforts that are community based rather than individually or organizationally based. Because these approaches have been reviewed elsewhere (Orlandi 1986; Perry 1986), only key features that are directly relevant to this monograph will be mentioned here.

First, most effective community-based health promotion efforts have as their underlying theoretical premise the principle of reciprocal determinism described above. In recognizing the relationships among the person, the person's behavior, and the environment, these approaches include multiple components directed at multiple organizational levels and multiple target groups within the community. In addition, the public health model aims interventions at the host (individual), agent (e.g., tobacco product manufacturers), and the environment (community laws, norms, mores, culture, etc.). Programs designed in this way can reach large numbers of individuals with cost-efficient interventions that are easily replicated.

Second, an emerging trend among community-based health promotion programs is the increase in program ownership, both perceived and actual, by community organizations and institutions rather than by program deliverers. This orientation, which derives from various theoretical approaches to community organization and community power analysis (Thomas 1990), establishes community partnerships composed of institutions, organizations, and interest groups within the community who collaborate on each aspect of program planning and implementation. It is currently being used in large-scale community-based health promotion efforts targeting tobacco use reduction (National Cancer Institute 1991) and alcohol and other drug use/misuse reduction (Office for Substance Abuse Prevention 1991) in scores of communities nationwide. Clearly, this orientation has great potential and will continue to be used in the effort to attain the Nation's health goals for the year 2000.

Third, as the community partnership approach is disseminated to various regions of the country and from one health promotion priority area to another, one concern that needs to be addressed more directly and aggressively is the representation of ethnic/racial subgroups in such collaborative processes. As has been reviewed elsewhere (Orlandi 1986), the tendency in the past has been for health promotion innovations to be introduced to and to demonstrate a benefit for the White Anglo-American mainstream population long before comparable advances are witnessed among nonmainstream groups. More recently, however, an increase has been noted in the development of intervention approaches that attempt to emphasize important culture-specific elements in their design (see Grace, Casas, Fleming, and Kim et al. in this volume). This raises the fundamental question: "How effective are these programs?"

Program Evaluation: The Art and the Science

As community-based prevention efforts proliferate, health professionals are beginning to find themselves face-to-face with a profound dilemma and a formidable challenge. The dilemma arises from these realities:

- Community-based partnership programs hold great potential for the control of AOD problems in our society as a whole.
- Within society as a whole, African Americans, Hispanics, American Indians/Alaska Natives, and Asian/Pacific Island Americans are ethnic/racial subgroups that have been underserved in the past and that need to be aggressively represented in health promotion initiatives in the future.
- The development and evaluation of community-based programs that can reach ethnic/racial subgroups within our society require expertise in two broad areas: program evaluation competence and cultural competence.
- Although they do exist, individuals who are competent in both areas are unfortunately rare.

The challenge consists of formulating a strategy for addressing this problem. However, before we deal with possible solutions, there are a number of issues related to the problem itself that should be examined. If we conceptualize this as a problem in communication or information flow, we can begin to analyze the barriers involved as a step toward addressing those barriers directly.

Developing the Evaluation Protocol

What are the barriers that must be overcome when the rhetoric of evaluation confronts the rhetoric of culture? When traditionally trained evaluators are presented with a program evaluation challenge, they typically begin by translating it into a series of *what, where,* and *when* questions. These questions, which deal with the workings of the program under review, are analyzed along dimensions that are infused into those evaluators during their training. These dimensions, which may be thought of as analytic perspectives for establishing an *evaluation protocol,* are often thought of by the evaluators as being grounded in scientific rigor and, therefore, objective. It is this impression that is often at the heart of the communication breakdown we are describing.

Although based substantially on scientific and methodologically rigorous principles, the decisions that are made in establishing an evaluation protocol are far from unbiased and are necessarily subjective in several important respects. Consider, for example, the following five dimensions.

Dimension 1: Formative Versus Summative Perspectives

Evaluations that interpret the developmental stages of a program as a means toward improving it are considered *formative.* Those that summarize a program's effectiveness over a specified period to help decisionmakers allocate funds and determine whether the program should be continued are considered *summative.* Confusion results when these two purposes of evaluation are confused or when community members or program representatives misconstrue a formative evaluation to be summative in its intent.

Dimension 2: The Three Levels of Evaluation Perspectives

Windsor and colleagues (1984, pp. 9–12) have made critical distinctions among three different levels of evaluation. Process evaluation, the first level, entails an assessment of ongoing operating procedures. It is often part of a quality assurance review, and it maintains a strictly formative perspective.

The *program evaluation level* involves an assessment of behavioral impacts that does not depend on experimental research design or random assignment. The main question addressed on this level is, did this program achieve the specific impacts intended in this particular setting? This level of evaluation strives to maintain internal validity and uses both formative and summative approaches.

The *evaluation research level* employs rigorous experimental designs, randomization to conditions, and multivariate data analyses. Both internal and external validity are critical to this level of evaluation, and the focus is on hypothesis testing rather than on formative or summative program statements.

Dimension 3: General Systems Versus Individual Component Perspectives

Evaluations that focus on individual components within a larger system, such as individuals within organizations or organizations within communities, are conceptualized differently—especially in terms of what constitutes program success or failure—than are evaluations that view the larger system as the unit of study. The most common error in this regard is to deliver a program to a particular segment of the community, such as members of an organization, and to evaluate it in terms of broader communitywide indicators.

Dimension 4: Qualitative Versus Quantitative Data Collection Perspectives

Many research questions can be appropriately addressed by means of qualitative data collection methods, including key informant interviews, participant observations, existing records analysis, and focus group studies. Other questions require quantitative procedures and a greater degree of methodological control. What determines the appropriate data collection procedure is the type of question being asked and the type of answer desired. When rigorous quantitative methods are either impractical or irrelevant, rigorous qualitative methods (Patton 1980) may be used.

Dimension 5: Social Marketing Versus Community Ownership Perspectives

Social marketing is an approach that relies heavily on direct input from members of a social program's target group during the formative evaluation stage of program development (Kotler

1982). Its purpose is to ensure that the knowledge, attitudes, and practices of the intended target group are taken into account during the design of an intervention program or its evaluation, rather than afterward. This process is unrelated, however, to the approach described as community partnership planning, through which program ownership is transferred to the community, even though focus groups—or "town meetings" that function very much like focus groups—are used in this approach as well. Thus, when an evaluator's full intent is not clearly specified, the potential confusion from the community's perspective is obvious.

Understanding the Evaluation Agenda

Clearly, the issues raised when attempting to answer the *what, where,* and *when* questions as a means of establishing the evaluation protocol could be the source of considerable confusion, frustration, and doubt if program evaluators and representatives fail to establish a common understanding with respect to any of these dimensions. Even more potentially troublesome, however, are the pitfalls inherent in trying to determine *who* is involved in the evaluation and *why* the evaluation is being conducted in the first place. If, for example, the basic rationale for conducting an evaluation is in dispute, the protocol that would be used is a moot point. These questions must, therefore, be answered prior to identifying the *evaluation agenda,* and, once again, several different dimensions are involved.

Dimension 6: Research Versus Service Delivery Perspectives

Whether evaluating a program at the process evaluation level, the program evaluation level, or the evaluation research level, an evaluator is often trained within and oriented toward a research perspective as opposed to a service delivery perspective. Practitioners, on the other hand, commonly have the opposite orientation. Who these individuals are with respect to this dimension will greatly influence their evaluation perspective; understanding that alternative perspectives exist will greatly enhance the communication process.

Dimension 7: Special Interest Group Perspective

Any process as complex as the design, implementation, and evaluation of an AOD problem prevention program will typically include a wide variety of interest groups, each of which will have a slightly different position on every evaluation question raised. Such groups include Federal, State, and local program staff; program developers; health educators; community activists; researchers; practitioners; community group leaders; and the general public.

Dimension 8: Implementation Versus Dissemination Perspectives

Although these perspectives are not typically thought of as being at odds with each other, an evaluation that primarily seeks to establish internal validity and individual program accomplishments is clearly different from one that tries to determine if a program is ready or appropriate for dissemination to other comparable sites. Misunderstanding in this regard may hinder the evaluation process considerably.

Dimension 9: Internal Versus External Evaluator Perspectives

Another dimension along which confusion can arise involves the issue of whether evaluation is carried out by individuals who are part of the system they are evaluating or by presumably objective outsiders. Because it is questionable that any evaluation can be value free, this issue can become reinterpreted as "our values versus your values." In this context, basic issues such as the salience of an evaluation approach or orientation may be called into question because of fundamental philosophical differences.

Dimension 10: Good Works Versus Good Work Perspectives

McKnight (1978) has distinguished two dramatically different perspectives toward what constitutes "a job well done" in the area of health and human services programs. One philosophy suggests that it is enough to work hard and tally the number of service contacts (good works) that are performed over time to demonstrate that a program is "working"; more should not be expected of individuals who are working hard and giving it their best. Alternatively, one might choose to evaluate progress based on measures that are more directly related to the program's goals and objectives. This position clearly would attempt to distinguish programs capable of attaining objectives such as reductions in AOD-related crimes (good work) from other programs. Again, the potential for intense disagreement is great, and the importance for addressing doubts related to this and the other nine dimensions is obvious. The question is, how?

Expert Linkage: A Three-Part Solution

The problem this chapter has addressed thus far can be summarized by figure 1. If the competence needed to evaluate AOD programs appropriately is to be found in two different groups, because few individuals have acquired both types of expertise, then several different approaches to program evaluation might be considered.

The approach labeled (a) in figure 1 suggests an evaluation that would rely only on individuals who are culturally competent, regardless of their levels of program evaluation competence. The approach labeled (b) would instead rely only on individuals who have program evaluation competence, regardless of their levels of cultural competence. However, there are obvious drawbacks in using either of these approaches.

The alternative labeled (c) is a variation of a method developed by Havelock (1971), called the *expert linkage* approach. This approach can be defined in terms of three basic components.

First, individuals who represent each of the relevant areas of expertise need to be brought together in an atmosphere of collaborative exchange. It is critical to the success of this approach that each area of expertise is accorded equal significance and that the collaboration's effectiveness is dependent on equal input and representation from each area. This approach is very much like the community partnership planning model that OSAP (1991) has espoused in that evaluators (or, in the terminology of this chapter, individuals possessing program evaluation com-

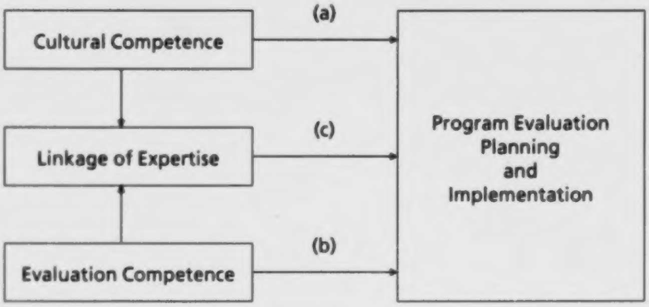

Figure 1. An Overview of the Linkage Approach to Program Evaluation Planning and Implementation

(a) Approach (a) involves developing program evaluation approaches with the aid of culturally competent individuals only.

(b) Approach (b) involves integrating expertise in the area of cultural competence with expertise in the area of program evaluation competence.

(c) Approach (c) involves developing program evaluation approaches with the aid of individuals possessing program evaluation competence only.

petence) enter into the collaborative planning process as one of the partners. When this approach is used, it is important to recognize that the goal is not for one particular position or orientation to "win out" over the others. Instead, the emphasis is on flexibility, strategic planning, and the practical use of available resources.

Second, to rectify the situation with which we are confronted, the number of individuals who are bicompetent in the areas of program evaluation competence and cultural competence must be increased. This will involve simultaneous efforts to enhance the program evaluation expertise of individuals who are already culturally competent, and vice versa. The need for comprehensive training programs in these areas is obvious.

Third, more individuals who are already bicompetent in these areas need to be identified so they may share their wisdom and, we hope, serve as change agents to advocate for the processes described as the first and second components.

Conclusion

The process described above is not so much a solution as a guideline for advancing the state of the art and the state of the science of culturally competent AOD program evaluation as soon as possible. To accomplish this, we must create opportunities for individuals who have something to contribute to the type of collaborative exchanges described.

Each of the authors in this monograph was asked the same question: If you had the opportunity to sit around a table and share what you know about cultural competence and AOD program evaluation with individuals who really wanted to learn more about these areas, what would you say? What follows are their replies.

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2

Of Kindred Minds: The Ties That Bind

Jacqueline P. Butler, M.S.W., L.I.S.W.

Abstract

African Americans are a culturally distinct group of people bound by an ideological unity and a functional system of values and beliefs. Their cultural ethos and worldview are inextricably woven together to give meaning and order to both their historical and contemporary experiences. An appreciation of these cultural elements is a prerequisite to understanding and interpreting their patterns of behavior. In this chapter African Americans, a highly complex and diverse people, are characterized in terms of the behaviors and lifestyle factors that make them a culturally identifiable entity. The chapter frames the African-American experience within its historical and contemporary contexts and focuses attention on the pervading conceptual frame of reference that has sustained and continues to sustain this people. The chapter's principal objective is to increase awareness and to enhance understanding of the core elements of African-American culture as they relate to the evaluation of alcohol and other drug use and misuse prevention efforts.

Introduction

As has often been said, the whole of any matter is greater than the sum of its parts. This statement is particularly useful in trying to understand and distinguish racial, ethnic, and cultural groups from one another. Although surface similarities and differences are readily apparent, observable, and describable, the dynamic connective factors and forces that give groups wholeness, uniqueness, and unity within their own diversity are usually of a different nature and are less easily discernible and recognized. Groups are bound together by the intangible, nonmaterial elements of culture. An awareness and understanding of the deepest level cultural components that identify and distinguish groups and give them meaning have practical as well as theoretical implications for those in the social science arenas.

Particularly in the areas of public health and welfare and, even more specifically, alcohol and other drug (AOD) services, the impact of fundamental cultural differences and the consequences of cursory knowledge and understanding have been brought to the forefront in recent years. Far too often, lack of real knowledge and awareness of the varying lifestyle patterns and needs of populations have resulted in inadequate service delivery, lack of compliance with expected norms and standards of behavior, and inconsistent or poor responses to caregivers and care facilities providing prevention and treatment services. Similarly, many factors that are peculiar to a specific population are often ignored in the development of social and public policies intended to provide assistance and needed services to this group.

Studies have clearly established the alarming disparity in health status between ethnic/racial and non-ethnic/racial groups. A look at the national picture in reference to African Americans underscores this disparity in the burden of death and illness and other morbidity factors. Particularly in the area of AOD services the case has been well established that African Americans have been underserved by traditional programs. Two primary reasons have been suggested for this gap in services: (1) poverty, which renders treatment inaccessible due to inability to pay and thus makes early intervention help unobtainable for ethnic/racial populations; and (2) the absence of culturally viable and acceptable treatment models, which would include recognition of the African-American worldview, behavioral and lifestyle patterns, and coping and problem-solving methods. In response to the alarming mortality and morbidity statistics for African Americans and the continuous unmet needs of this population, efforts have become more focused on creating and promoting culturally appropriate services. Such services are intended to respond in design, content, and staffing patterns to the values, belief systems, and behavioral patterns of the affected cultural group—in this case, African Americans.

The experiences of African Americans have generally been characterized and described along two dimensions—one in terms of interactions and responses to interactions with European Americans and the other in terms of their own internal dynamics, both as individual personalities and as a collective group. African-American history is not synonymous with American history, nor are all significant aspects of life those that relate to cocultural dynamics. African Americans have a story to tell that is unmistakably their own. Their history is unique, based on their rich cultural heritage, not all of which was lost in their transplantation to America or on the plantations where contact with European Americans recurred regularly. Despite insults to their humanity; psychological disorientation; and the social, cultural, and environmental displacement experienced during their early years in America and after, African Americans have managed to defy the forms of enslavement (both physical and psychological) and have attested in every media and form to their resiliency as a people and to the tenacity of their cultural heritage. Old cultural patterns have persisted; some have been reinterpreted; others have been syncretized and adapted to fit the environment. Through it all and at each stage of development a consistent mode of thought has prevailed.

The ties that bind African Americans together define their essential nature as a historically and culturally distinct group. These ties provide the "cultural key" for interpreting, understanding, and making meaningful a description of African-American life in American society. Making explicit the core elements of African-American culture and the unifying forces that give depth and dimension to the dynamics and character of this group will aid in differential attempts to design programs on the group's behalf.

Framing the Information

"To be changed from a chattel to a human being, is no light matter . . ." (Bibb 1850, p. 10).

African-American social and cultural patterns reflect the historical circumstances and challenges with which African Americans have had to contend. The quest for identity could easily be considered the major theme of African-American existence in the Western world. While also characteristic of the experiences of most hybrid Americans who have had to contend with transplantation and adjustment, the effects of social, cultural, and environmental contact and change have been, in many respects, more devastating and intense for African Americans because of the uniqueness of their journey to the Americas and their experiences in the American world (Mintz 1970). Throughout their history, African Americans have been in the process of creating their own cultural reality and recreating a self-identity commensurate with their human nature.

Although African Americans have always been a part of American society, their world, with its distinctive expressions, has run parallel and sometimes even counter to the mainstream American culture. Social existence for African Americans has been problematic since their earliest days on American soil. Members of this racial, ethnic, and cultural group have experienced the deepest levels of social disequilibrium and nonacceptance. Life for African Americans has largely consisted of an incomplete existence based on the compromises of the essential self that had to be made to adapt and survive in what has been called a "hostile environment." Leon Chestang has identified three conditions that shape character development in such an environment.

> *Three conditions, socially determined and institutionally supported, characterize the black experience: social injustice, societal inconsistency, and personal impotence. To function in the face of any one of them does cruel and unusual violence to the personality. To function in the face of all three subjects the personality to severe crippling or even destruction. These three crucial conditions, however, confront the black person*

> *throughout his life, and they determine his character development (Chestang 1972, p. 2).*

These three conditions contributed to two forms of behavior among African Americans that, according to Chestang,

> *resulted in the development of two parallel and opposing thought structures—each based on values, norms, and beliefs supported by attitudes, feelings and behaviors—that imply feelings of depreciation on the one hand and a push for transcendence on the other.... the transcendent [character] differentiates itself from the depreciated [character] by this central trait. The depreciated will sell its soul to survive, the transcendent will give its life to be (Chestang 1972, pp. 4–5).*

The historical record for African Americans in this society has consisted of sociocultural adaptation and survival processes. The opportunity to develop true potential in an environment free of racism and oppression has been theirs (when at all) only peripherally. Instead, they have had to shape their character in an environment that often has been antithetical to their welfare and that has violated many of the traditional practices that were legitimately their own. Many socialization processes were completely interrupted; in particular, the transitional stages from childhood to adulthood were minimized and, for the most part, disregarded. This has had a tremendous impact on the development of the African-American character and personality and, consequently, behavioral patterns.

According to B.M. Magubane, "The identity of every people is shaped by the environment. It is a legacy of historical forces" (1989, p. 10). Wade Nobles has expressed this view in another way, stating that the "uniqueness of one's environment determines the parameters of one's experience" (1972, pp. 25). Nobles has also defined three significant time periods that have been used to describe the experiential communality of Africans living in the Western world, particularly in North America: (1) the African experience (prior to 1600), (2) the slavery experience (1600–1865), and (3) contemporary Black America (1865 to the present) (Nobles 1972). Slavery is considered the pivotal period and the one to have most profoundly affected the identity of

African Americans and the unfolding of their true selfhood as men and women. Not only were African Americans removed from a strong cultural heritage and required to reestablish a cultural identity during slavery, but they were also denied the essence of their very nature as human beings. Consequently, finding the way back to full man- and womanhood in this society has been a monumental task (and one yet to be fully accomplished).

W.E.B. DuBois (1903) has described the effects of transplantation and adjustment on the personhood of African Americans. He characterizes the history of African Americans in terms both of a duality of self and of always living with a sense of double-consciousness, striving to become one whole person: "The history of the American Negro is the history of this strife—this longing to attain self-conscious manhood, to merge his double self into a better and truer self" (DuBois 1903, pp. 3–4). Howard Thurman also has described the effects of slavery on the personhood of the slaves, but in transcendent terms:

> *They [the slaves] made a worthless life, the life of chattel property, a mere thing, a body, worth living. . . . To them this quality of life was insistent fact because of that which deep within them, they discovered of God, and His far-flung purposes. God was not through with them. And he was not, nor could He be exhausted by, any single experience or any series of experiences (Thurman 1975, p. 56).*

The term *diaspora* has been used to characterize further the transplantation and dispersion of innumerable men and women from Africa to North and South America by way of the Atlantic. More than four centuries separate the descendants of these dispersed people from their forebears, and yet there remains a oneness, a rhythmic unity (Asante and Asante 1990, p. 4), a depth of knowing and understanding that has been felt from that time to the present. The sharing of a common heritage, a common set of experiences, a common culture, and an emotional bond kindled by an awareness of their interrelatedness with preceding generations defines the ethos of the African-American people.

The ethos of a people refers to the special characteristics that identify them as a group and set them apart from other groups. The African-American ethos is spiritual. It derives from the African heritage and has been maintained by shared experiences and common historical circumstances (Asante and Asante 1990, p. 208). These commonalities have created a sense of oneness and unity among African Americans. It is this collective ethos that provides the common sentiments and emotional responses of the group. It is this same ethos that grounds African Americans and that has, at every point in time, caused men and women to rise up and take a stand, regardless of the consequences. This ethos is the spiritual connective force that gives essence to the African-American worldview.

The worldview of African Americans represents their general design for living and patterns for interpreting reality. It is how they make sense of their world and their experience as it determines which events are meaningful and which are not and provides the process by which those events are made harmonious with their lives. More accurately, the African-American worldview might be conceived best as an ideological perspective or "a philosophical outlook determined by history" (Asante 1988, p. 27). Accordingly, this worldview is Africentric; that is, it is rooted and centered in its African genesis. The Africentric worldview brings together all aspects of African metaphysics (i.e., ontology, axiology, epistemology, and cosmology). Its philosophical components have been described in detail by such contemporary writers as Edwin Nichols (1985), Molefi Asante (1988), and Linda James Meyers (1988).

The African-American worldview is made manifest through the language, symbols, customs, values, and ideas of the people. In recent years, it has been given even more concrete expression and been made functional for contemporary purposes. Maulana Karenga has defined the seven foundational principles that compose the African-American value system (Perkins 1986, pp. 198, 201–202; Karenga 1988, pp. 43–73). These principles of the Nguzo Saba (or the Black Value System) (see fig. 2) have become widely acknowledged and accepted as the guiding standards for functioning in an Africentric frame of reference.

Value	Meaning
Umoja	Unity
Kujichagulia	Self-Determination
Ujima	Collective Work and Responsibility
Ujamaa	Cooperative Economics
Nia	Purpose
Kuumba	Creativity
Imani	Faith

Figure 2. Nguzo Saba

Source: Perkins 1986, Karenga 1988.

As is true for all cultural groups, the core elements of African-American culture exemplify the group's individual and collective reality. They establish the group's identity and differentiate it from other groups. For African Americans, the core elements define who they are (Self-identity), what they know (Knowledge), what they feel (Emotions), and how they behave (Behavior) (see fig. 3). Each core element of the culture represents a distinct but interwoven manifestation of the African-American cultural reality. The categorization and classification of the core elements of African-American culture is to attempt to make tangible and perceptible the African-American ethos, worldview, and value system, which, as stated above, are intangible and essentially imperceptible.

Self-Identity

Who are African Americans and what makes them significantly different from any other cultural group? By definition, they are group members. The identity of each individual is inseparably tied to that of the group. The self is considered an "extended self" that is validated only by its functioning in relationship and in harmony with the collective whole. Based on the extension of

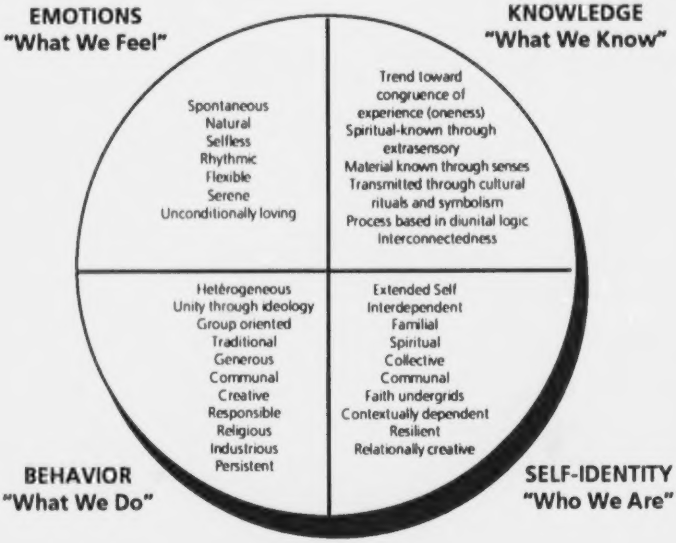
EMOTIONS
"What We Feel"
KNOWLEDGE
"What We Know"
Spontaneous
Natural
Selfless
Rhythmic
Flexible
Serene
Unconditionally loving
Trend toward
congruence of
experience (oneness)
Spiritual-known through
extrasensory
Material known through senses
Transmitted through cultural
rituals and symbolism
Process based in diunital logic
Interconnectedness
Heterogeneous
Unity through ideology
Group oriented
Traditional
Generous
Communal
Creative
Responsible
Religious
Industrious
Persistent
Extended Self
Interdependent
Familial
Spiritual
Collective
Communal
Faith undergrids
Contextually dependent
Resilient
Relationally creative
BEHAVIOR
"What We Do"
SELF-IDENTITY
"Who We Are"

Figure 3. Core Elements of African-American Culture

African philosophical tradition, Nobles has explained the concept of the "extended self" as follows:

> *One's self-definition is dependent upon the corporate definition of one's people. In effect, the people definition* transcends *the individual definition of self and the individual conception of self* extends *to include one's self and kind. The transcendent relationship (that between self and kind) is the* extended self *(Nobles 1980, pp. 103–104).*

The concept of self-identity is perhaps best captured by the increasingly familiar expression, "I am because we are; and because we are, therefore I am" (Mbiti 1970, p. 103). As African Americans become more consciously aware of their rich cultural heritage and strive to demonstrate and actualize their recognition of who they are in all dimensions of life, their interrelationship with and interdependence on past and present generations become vitally apparent.

Knowledge

The nature of knowledge for African Americans includes both what is known through the senses and in an extrasensory fashion. Spirit gives essence to the life form, which in turn provides concreteness to the spirit; the two are one. The world is seen from an optimal perspective (Meyers 1988, pp. 7–15) in which all things can exist in harmony. Diunital thinking (the co-existence and interconnectedness of opposites) and characterizing of material phenomena and spiritual forces allow for the fullest expression of one's reality. Rituals, symbols, and language are the vehicles by which knowledge is transmitted from generation to generation. Life experiences are given depth and meaning through the realization of their interrelatedness and significance in the life and existence of the group.

Emotions

African Americans are a highly expressive people. Because of their sense of oneness with life and of harmony with nature, they respond naturally and spontaneously to experiences. Their rhythmic sense of balance characterizes their physical movements as well as their interpersonal understandings and interactions. Versatility and flexibility are two of their most positive assets. These two attributes have contributed greatly to their ability to adjust and adapt to the many pernicious experiences they have had to face. Because of these two primary attributes, as well as the many others that are a part of their emotional composition, African Americans have been able to protect, preserve and maintain their deepest sentiments and traditional responses to people and things. As with all aspects of their culture, the emotional nature of African Americans is characteristic of their African cultural heritage.

Behavior

Who African Americans are, what they know, and what they feel are manifested in their modes of behavior. The behavior is an abstracted form as opposed to a concentration on concrete rules and standards. African Americans socialize and become socialized through a "tacit" conditioning process (a process by which the group picks up "modes, sequences, and styles of behavior" [McAdoo and McAdoo 1985, p. 42] through their day-to-day encounters) rather than through directed or explicit modes of conditioning. The focus for African Americans is on the creative synthesis of experiences. The essence of form is sought and duplicated.

> *Black cultural styles are enacted by Black parents (and other family members and friends) and passed on to the children essentially because such are habitual forms of behavior, ingrained patterns of action, motifs that are displayed with such consistency and that help to provide an ambience so compelling that the child can pick them up through an unarticulated conditioning process. Black cultural motifs, thus, can get conditioned even as parents might belie what they articulate to be their values and child-rearing objectives (McAdoo and McAdoo 1985, p. 42).*

Dr. Na'im Akbar (1981, pp. 7–14) has described six trends that are indicative of African-American behavioral patterns. In his discussion, he has captured many of the subtle characteristics of African-American behavior that often go unrecognized and misunderstood. While Dr. Akbar has described these trends with particular reference to African-American children, they are considered accurate and important enough to be extended in the following summary to African Americans in general. The six trends are described below.

1. *African-American Language*

   African-American language is at best a symbolic expression of the mental contents of the group. The variation that exists in the language reflects the verbal attempt to capture and express the different mental experiences of African Americans. The language that has evolved is based upon certain shared experiences and agreed upon symbols for the expression of those experiences. The African-American mental experience is highly affective and is marked by considerable feeling. Many characteristics of the English language fail to reflect the subtleties of emotions of this highly affective and sensitive people.

The limited and contextual meaning of the language is given additional flexibility by the considerable amount and highly meaningful body language adopted by the African-American speaker. The African-American body language is a modality for maintaining rhythm in expression as well as dramatizing that which the language fails to communicate. In fact, the body language of African Americans might be viewed as a highly exquisite form of pantomime. It is because of the many subtle patterns of African-American language and body language that African Americans are often misunderstood when communicating with unfamiliar persons.

2. *Oral Patterns*

The importance of oral or spoken communication to the African-American lifestyle is an example of one of the many continuities with African tradition maintained in the African-American experience. Oral communication remains the predominant means of information transmission within the African-American community. While Euro-American people demonstrate a highly developed visual orientation as is evidenced by the heavy emphasis on written material that characterizes American culture, African Americans rely much more on the spoken word than on the written word. The emphasis on spoken communication results in a highly developed auditory and listening facility on the part of African Americans. African Americans develop acute sensitivity to subtleties in expression and intonation often unobserved by Euro-American speakers. Consequently, African Americans respond to unexpressed prejudices and hostility on the part of non-African Americans, even when feelings are carefully camouflaged.

African Americans demonstrate considerable superiority in aural-motor coordination. The dancing ability of African Americans—which is actually the translation of certain auditory cadences into motor activity—is an excellent example of their aural-motor coordination. Unfortunately, however, African Americans live in a broader culture where visual-motor activity is the measure of excellence as opposed to aural-motor activity. Recognition of the difference between the two types of motor skills is critical for instructional purposes and for the educational development of African-American children. Understanding their highly developed facility holds the key to some of the educational deficiencies confronting African-American children and the American educational system.

3. *People Orientation*

One very important element of the African-American oral tradition which distinguishes it from the visual tradition of the Euro-American culture is the centrality of a speaker in the former case and his dispensability in the latter. The crucial difference indicates another significant characteristic of the African-American cultural experience. This characteristic is the considerable "people orientation" of the African culture. Experiences are significant to the degree that they relate to people in some very direct way. The dual medium of the spoken word and the living person serve to motivate African-American people. Effective communication in the African-American tradition consists of a correlation between the rhythm and content of a message or the message and medium. The rhythms, the cadence of the storyteller is as important as what he is saying. The marked group orientation among African Americans, which stands in sharp contrast to the wider cultural norm of individualism, is another important example of the people orientation characteristic throughout the African-American life experience.

4. *Interaction vs. Reaction*

Another pattern of considerable prominence found in the African-American life experience is the interactional pattern of call-and-response. This pattern has its most dramatic example in the African-American churches in which one finds the preacher's speech transformed into a litany of sentences and responses from the listeners. The spontaneous reactions and supportive statements of encouragement involve the speaker and listeners in a dialogue of interaction. This stands in contrast to the traditional Euro-American speaker/audience setting in which the speaker or expert dispenses wisdom and the audience listens attentively and reacts only at appropriately defined moments.

This pattern, though most colorful in the speaker setting, is a pervasive occurrence within African culture. This ongoing system of interaction and social reinforcement maintains relationships between people in almost all settings.

5. *African Thought*

Another distinctive characteristic of African Americans is the form of thinking and problem solving that they have gained from the conditioning of their cultural and life experience. This characteristic is a strong reliance on internal cues and reactions as a means of problem solving in contrast to the enforced reliance on external cues. There is a cultural respect for internal cues and "hunches" as a means of acquiring information and knowledge. Despite the scientific unreliability of this form of information getting, it offers some advantages that reliance on the external simply cannot produce because of its limitations in time and space.

The reliance on intuition is very adaptive in an environment in which learning and problem solving usually occur in relationship to people. Such inner processes are very informative about the inner processes of other people and provides information beyond the particular information that is verbally communicated. The reliance on intuition, therefore, allows African Americans to be particularly empathetic and adept in social relations.

6. *Spontaneity*

Another highly distinguishing characteristic of African Americans is the capacity to be spontaneous—the facility for easy, rapid adaptation to different situations. The capacity to respond quickly and appropriately to environmental changes is one of the African American's most remarkable strengths. It facilitates his/her basic comfort in most settings, where there are positive interpersonal relations.

African Americans' spontaneity is as present in their rapid adaptation to new environments as it is in other aspects of behavior. Their motor activity is spontaneous and well-coordinated, and they are equally spontaneous with their feelings, generally responding directly and honestly.

Dr. Janice E. Hale-Benson (1986, pp. 15–17) has also described aspects of contemporary African-American culture that reflect the African cultural tradition. These aspects of culture are either preserved directly or have been modified in some respect as a result of environmental adaptation. The observable equivalent cultural aspects are the following:

- Funerals
- Magical practices
- Folklore
  (Uncle Remus stories are similar to the sacred myths of Africa.)
- Dance
- Song
- Motor habits (walking, speaking, laughing, sitting, posture, burden carrying, dancing, singing, howing, and movements made in various agricultural and industrial activities)
- Way of dressing hair (wrapping, braiding, cornrowing)
- Wearing of handkerchiefs, scarves
- Etiquette
  (In African societies the ancestors are the most respected strata of the family. The elderly are the closest to the ancestors; therefore, they are accorded a great deal of respect. Consequently, African Americans of the diaspora have been observed to accord great respect to the elderly.)
- Cooperation and sharing
- Child-rearing practices

- Adoption of children
  (However, an informal system of adoption operates, within which usually older women will provide for children when their families need assistance.)
- Myths about abnormal births
- Child-naming practices
- Audience and performer styles
  (A higher emotional interaction exists between African-American performers and audiences, with a great deal of call and response.)
- Religious and spiritual expressive styles and highly emotional overtones to worship
- Conception of the devil

Heterogeneity

Three processes that require discussion as to the heterogeneity of African Americans include cultural patterning, cultural adaptation, and cocultural dynamics.

Cultural Patterning

This refers to the "patterns of socially acquired behaviors and their consequences [that] are carried in time and space by descendants of a historical group" (Mintz 1970, p. 3). Cultural patterning persists despite a drive toward homogeneity. Patterns of socially acquired behaviors and their consequences have been carried from generation to generation of African Americans. These behaviors include—but are not limited to—such things as child rearing, communication, food preparation, age grading, sports, bodily adornment, cleanliness training, cooperative labor, courtship/marriage/sex, dancing, education, ethics, etiquette, family feasting, storytelling, food taboos, funeral rites, games, gestures, gift giving, greetings, hospitality, housing, hygiene, joking, kinship patterns, kin groups, language, luck/superstition, eating patterns, healing practices, modesty concerning natural functions, mourning, music, problem solving, puberty customs, religious rituals, sexual restrictions, and status differentiation.

On a macro level, four systems within the African-American community—that is, church, community, neighborhood, and social organizations—have been the major vehicles for providing cultural focus, cultural patterning, and social development. Examination of these four systems reveals specifics with respect to their distinctive functioning.

Church

Organized religion has provided the major vehicle for socialization in the African-American culture. As the center for the extended family, reinforcing the sense of self and self-esteem within the culture, the church offers opportunities for the whole family's development.

> *Probably no other single institution has played such an important role in maintaining the cohesion of black society as the black church. As E. Franklin Frazier [The Negro Church in America. New York: Schocken Books, 1963:30] concluded: "An organized religious life became the chief means by which a structured or organized social life came into existence among the Negro masses" (Jaynes and Williams 1989, p. 173).*

The only "foundational social institution of America that was ever readily available to African Americans" (Noble 1978, p. 69) throughout their history in the United States has been the Christian church. Because African Americans came to this country with innate spirituality, the Christian church quickly became the most influential African-American institution. Today it is the cornerstone of African-American aesthetic and recreational life as well as a political base for tranquilizing the rage generated by oppression. It is also a major resource to sustain African Americans through their pain and hurt. The church serves as an agency of moral guidance and social control; it is the center of African-American community life.

Community

Within the African-American culture, a community provides several essential elements. These include an opportunity for leadership roles, the vehicle for integrating and coordinating the multiple institutions that operate on the micro level, a protective barrier to isolate the group from the negative dynamics of racism, and the structure necessary for the transmission of culture.

Neighborhood

Neighborhoods refer to the *blocks* on which African Americans live. These are the smaller divisions of the community that primarily provide for a mutual aid and support system.

Social Organizations

These organizations have allowed for the African-American values of unity, self-determination, collective work and responsibility, cooperative production, purpose, creativity, and faith to be operationalized. Although many African-American social organizations have organizational structures similar to those of their White counterparts, they have imbued their activities with their distinctive worldview. These social organizations contribute to African-American activity, both socially and in community building.

Cultural Adaptation

This second variable refers to survival strategies. Historically, these strategies were oriented toward the goals of assimilation and acculturation. They often included emotional defense mechanisms such as rage, humor, seduction, and compliance. These survival strategies are manifest today through stages of African-American identity development. William E. Cross outlines a model that consists of five stages: preencounter, encounter, immersion-emersion, internalization, and internalization commitment (Cross 1980). These stages describe the process through which African Americans are able to negotiate their existence in a dual-culture environment.

Cocultural Dynamics

The third variable refers to the African American's experience in accommodating dual-culture expectations. Almost a hundred years ago, W.E.B. DuBois wrote: "One ever feels his twoness—an American; a Negro; two souls, two thoughts, two unreconciled strivings; two warring ideals in one dark body, whose dogged strength alone keeps it from being torn asunder" (DuBois 1903, p. 3). One can also use the more contemporary work of Peter Bell and Jimmy Evans (1981) to illustrate the range of styles that express cocultural dynamics. They have identified four primary interpersonal styles: acculturated, bicultural, culturally immersed, and traditional. They have noted that, although these styles can be used to describe the cocultural dynamics of African-American populations, they are not fixed styles and they primarily serve to protect African Americans in an oppressed society. Bell and Evans (1981, pp. 28–29) further suggest that, because of racism and oppression, the African American must be understood through a double-consciousness model. Figure 4 illustrates such a model and its corresponding interpersonal styles.

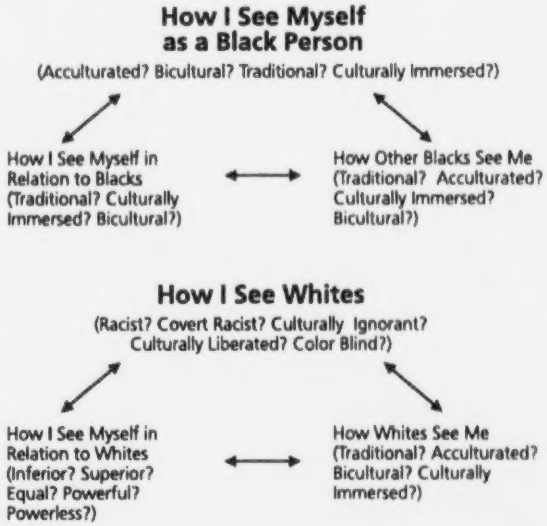
How I See Myself as a Black Person
(Acculturated? Bicultural? Traditional? Culturally Immersed?)
How I See Myself in Relation to Blacks (Traditional? Culturally Immersed? Bicultural?)
How Other Blacks See Me (Traditional? Acculturated? Culturally Immersed? Bicultural?)
How I See Whites
(Racist? Covert Racist? Culturally Ignorant? Culturally Liberated? Color Blind?)
How I See Myself in Relation to Whites (Inferior? Superior? Equal? Powerful? Powerless?)
How Whites See Me (Traditional? Acculturated? Bicultural? Culturally Immersed?)

Figure 4. "Black Double-Consciousness"

Source: Bell and Evans 1981.

Economics

Within the context of the culture, resources lend life support to the entire community. Although the well-being of both African Americans and Whites has advanced greatly over the last five decades (Jaynes and Williams 1989, p. 6), findings on the economic status of African Americans in the late 1980s continue to indicate that they remain substantially behind Whites in almost all aggregate statistical measures. Gerald Jaynes and Robin M. Williams offer a more complex set of indicators that reveal the relative status of African Americans:

- ♥ The greatest economic gains for Blacks occurred in the 1940s and 1960s. Since the early 1970s, the economic status of Blacks relative to Whites has, on average, stagnated or deteriorated.
- ♥ The political, educational, health, and cultural statuses of blacks showed important gains from the 1940's through the 1960's. In addition, some important indicators continued to improve after the early 1970's.
- ♥ Among blacks, the experiences of various groups have differed, and status differences among those groups have increased. Some Blacks have attained high-status occupations, income, education, and political positions, but a substantial minority remain in disadvantaged circumstances (Jaynes and Williams 1989, p. 6).

Jaynes and Williams go on to identify three factors that have been major precipitants of the patterns described above:

- ♥ Political and social activism among Black Americans and their White allies led to changes in governmental policies; particularly important were sweeping improvements in the legal status of Blacks.
- ♥ Resistance to social change in race relations continues in American society.
- ♥ Broad changes in overall economic conditions, especially the post-1973 slowdown in the Nation's economic growth, have significantly affected social and economic opportunities for all Americans (Jaynes and Williams 1989, p. 6).

African Americans have no absolute means of income (i.e., ownership and control of major economic resources), only accumulated wealth. Because African Americans were compelled to separate from all direct historical linkages to economic resources in their early history in America, there exists a major disparity between African Americans and other American groups—and among African Americans themselves—in established economic resources. To date, the reestablishment of linkages with traditional cultural means of economic self-sufficiency (i.e., marketing, access to land for farming, hunting, gathering, means for buying and selling, etc.) have not been effectively accomplished. Although significant gains have been made by many African Americans, economic self-sufficiency—or even a semblance of economic stabilization—is far from the grasp of the majority.

Additionally, it is important to stress that, economically, there has been a shift away from an emphasis on the "collective good" and toward an increased focus on individual attainments and personal gains. This shift has resulted in a further erosion of their cultural foundation and quality of life. But despite these challenges, many members of the African-American culture remain committed to the creative restoration of its once-viable means of self-sufficiency. The values strongly promoted in contemporary African-American communities—based on the Nguzo Saba and other Africentric principles—reflect the deep commitment to reconnecting African Americans with their traditional sources of life skills and economic survival practices.

Marriage and Family

African-American families come in all forms: the nuclear family, the extended family, the augmented family, and the alternative family. All these forms have been affected by historical, economic, and political forces. Andrew Billingsley has defined the African-American family as follows:

> *It is an intimate association of persons of African descent living in America who are related to each other by a variety of means including blood, marriage, formal adoption, informal adoption*

> *or by appropriation; [are]sustained by a history of common residence; and are deeply imbedded in a network of social structures both internal to and external to themselves (Billingsley 1990, p. 87).*

African-American family forms have responded to the challenges and complex demands of their environments.

African-American families also range across the entire spectrum of social classes in America. Billingsley identifies five distinct social class strata:

> *(1) The underclass, consisting of poor families where no member has a permanent attachment to the work force; (2) The working poor, where despite working for low wages, they are not able to earn above the poverty line; (3) The nonpoor working class, composed of unskilled and semi-skilled blue-collar workers with earnings above the poverty line; (4) The middle class, comprised primarily of white-collar skilled and professional workers with family income above the median for all families; and (5) A small black upper class of families with high incomes and substantial wealth as well as social and economic influence (Billingsley 1990, p. 96).*

Contrary to popular belief, single-parent families do not constitute the majority of African-American families, except among the two lowest socioeconomic levels (Billingsley 1990). Although the number of such families appears to be on the rise, it is important to note that the value of marriage is still strongly evident among African Americans, particularly in the younger generations.

Marriage in the African-American tradition "is not simply a union between two people, but between groups of people" (Billingsley 1990, p. 87). Billingsley describes it as a "kinship unit," within which blood ties supersede marital bonds. This is not to say, however, that the sanctity of marriage is not respected and protected. Traditionally, African Americans have had to rely on the support of their extended family and kinship relations. The multigenerational contributions are considered essential to the continuous growth, development, and stabilization of marriage, both psychologically and materially.

Male/Female Relationships and Gender Roles

An African-American woman contemplating marriage is expected to choose "a good man"—one who will treat her right, who will provide for her (most important), and who will feel obligated to take care of his children (Martin and Martin 1978, p. 60). An African-American male contemplating marriage will usually look for a woman who is easy to get along with, who is willing to be monogamous, and who is capable of fulfilling the organizer role. He may seek a woman willing to work and help supplement his income; and he wants someone he finds attractive and sexually satisfying, and who allows him enough freedom so that he does not feel stifled by the marriage (Martin and Martin 1978, p. 60).

Gender roles within the African-American culture are egalitarian with respect to expressive levels and functional responsibility. African-American males do not perceive their manhood solely according to their ability to provide security or stability to the family. Rather, there are other parameters (i.e., their ability to adapt to an oppressive environment, the ability to survive without assistance and support from mainstream institutions, etc.) that serve to regulate their sense of self. The increasing stress of socioeconomic and political oppression has altered norms, standards, and perceptions of healthy male/female relationships. Nevertheless, as has been stated previously, high value is still placed on marriage and family life in the African-American community.

Intergenerational Relationship

Child rearing in the African-American family tradition rests on religious beliefs, strict discipline, respect for parental authority, and reliance on experience as the teacher (Mbiti 1970, p. 29). These traditions were handed down to the elders from generations before them and, believing that the old-fashioned ways of preparing young members for living in America have maintained the family and the welfare of its members, the elders still seek to impart those ways to the young. "Strength, perseverance, hope, and faith" (Mbiti 1970, p. 29) are what the elders have sought to pass on through the generations.

Traditionally, intergenerational relationships provided the fundamental process for transmitting cultural values and expectations, and they were sustained by the proximity of the young to the old. More recently, however, the socioeconomic and political stressors of society have complicated the ability of the extended units to remain in intimate contact. As a consequence, the character development of younger generations has been severely impaired, particularly around values pertaining to religion, discipline, education, work, sex, marriage, mutual aid, race identity, and death.

Kinship: Collective Unity

African Americans as a group are held together by a traditional system of kinship ties. Kinship controls all relationships in the community and binds together the interdependent relationships of all members of the group. The kinship system is deeply rooted in the African tradition, which established the relationship of every living form to another.

> *"In traditional life, the individual did not and could not exist alone" [Mbiti, 1970]. The individual owed his very existence to other members of the "tribe." Not only those who conceived and nourished him but also those long dead and still unborn. The individual did not exist unless he was corporate or communal; he was simply an integral part of the collective unity. Africans believed that the community (tribe) made, created, or produced the individual; thus, the existence of the community was not imagined to be dependent on individual ingression. . . . Whatever happened to the individual happened to the corporate body, the tribe, and whatever happened to the tribe happened to the individual (Nobles 1972, p. 25).*

Despite an emphasis on rugged individualism and individual competition in the mainstream culture, the African-American sense of corporate responsibility and collective destiny still remains prevalent and is one that contemporary groups are seeking to revitalize.

Education

Education among African Americans is a primary area where cultural differences in approaches to achievement are most apparent. Although the African-American culture has been characterized by a strong orientation toward acquiring knowledge, the means by which the learning was accomplished has varied markedly. Education in the African-American culture has incorporated in the past and continues to incorporate both formal and informal systems.

Formal systems of education have not always been available or accessible to African Americans. Consequently, and in harmony with the cultural tradition of their African heritage, informal methods of obtaining and imparting knowledge were reinstated or cultivated. Such processes as modeling and mentoring; apprenticeship, craftsmanship, and entrepreneurial programming; and school learning (whether in public, private, independent, or church schools) have been used to educate, instruct, and train African Americans.

The extent to which educational systems are compatible with the African-American cultural cosmology determines whether the system will yield positive results. Differences in the educational achievements experienced by African Americans are closely tied to teacher behavior and attitude; the social and political climate; and the content, quality, and organization of instruction, including sociolinguistics, dialect, and social context.

The learning styles of African Americans are an extension of their worldview and cultural ethos. As a result, the relational learning style has been found to maximize the potential for academic success better than the less characteristic but more common, traditional, analytical style of the larger American culture. This fact has had grave consequences for many African-American children and adults in many aspects of their social welfare. Figure 5 provides a view of the two contrasting learning styles (Hale-Benson 1982, pp. 32–33).

Analytical Style	Relational Style
Stimulus centered	Self-centered
Parts—Specific	Global
Finds nonobvious attributes	Fine descriptive characteristics
Notices formal properties of a stimulus that have relatively stable and longlasting meanings	Identifies the unique
Ignores the idiosyncratic	Ignores commonalities
Extracts from embedded context	Embedded for meaning
Names extracted properties and gives them meaning in themselves	Relevant concepts must have special or personal relevance to observer
Relationships tend to be linear	Meanings are unique, depending upon immediate context
Relationships that are noticed tend to be static and descriptive rather than functional or inferential	Generalizations and linear notions are generally unused and devalued
Relationships seldom involve process or motivation as a basis for relations	Parts of the stimulus and its nonobvious attributes are not given names and appear to have no meaning in themselves
Perception of conceptual distance between observers and observed	Relationships tend to be functional and inferential
An objective attitude—a belief that everything takes place "out there" in the stimulus	Since emphasis is placed on the unique and the specific, the global, and the discrete, on notions of difference rather than on variation or common things, the search for mechanism to form abstract generalizations is not stimulated
Stimulus viewed as formal, long-lasting, and relatively constant; therefore opportunity exists to study it in detail	Responses tend to be affective
Long attention span	Perceived conceptual distance between the observer and the observed is narrow
Long concentration span	The field is perceived as responding to the person
Greater perceptual vigilance	The field may have a life of its own
A reflective attitude and relatively sedentary nature	Personification of the inanimate
Language style is standard English of controlled elaboration	Distractible
Language depends upon relatively long-lasting and stable meanings of words	Emotional
Language depends upon formal and stable rules of organization	Overinvolved in all activities

Communications are intended to be understood in themselves, i.e., without dependence upon nonverbal cues or idiosyncratic context	Easily angered by minor frustrations
"Parts of Speech" can readily by seen in nonsense sentences	Immediacy of response
Analytic speech characterized by "hesitation phenomena"; pauses for verbal planning by controlled vocal modulation and revision of sentence organization to convey specific meanings, since words have formal meanings	Short attention span
Sometimes view of self expressed as an aspect of roles, such as function to be performed	Short concentration span
View of self tends to be in terms of status role	Gestalt learners
	Descriptive abstract for word selection
	Words must be embedded in specific time-bound context for meaning
	Few synonyms in language
	Language dependent upon unique context and upon many interactional characteristics of the communicants on time and place, on inflection, muscular movements, and other nonverbal cues
	Fluent spoken language
	Strong, colorful expressions
	Wide range of meaningful vocal intonation and inflection
	Condensed conditions, sensitivity to hardly perceptible variations of mood and tone in other individuals and in their surroundings
	Poor response to timed, scheduled, preplanned activities that interfere with immediacy of response
	Tends to ignore structure
	Self-descriptions tend to point to essence

Figure 5. Comparison of Analytical and Relational Cognitive Style

Source: Hale-Benson 1986.

Migration

The African-American pattern of migration has been linked to the economic base of the American society. For example, from 1939 to 1969, migration of African Americans northward and their concurrent shift from agricultural to nonagricultural employment accounted for the major economic progress of the group (Jaynes and Williams 1989, p. 18). This period, commonly referred to as the "Great Migration," also produced some of the most significant political inroads for this population. It is reported that, beginning in 1940, there was a net outmigration from the South of 1.5 million African Americans; the net total outmigration between the years 1940 and 1970 has been estimated at 4.3 million persons (Ploski and Williams 1989, p. 473). This has continued a trend toward northward migration into urban areas that has contributed to the present disproportionate representation of African Americans in major northern metropolitan areas.

This massive African-American migration has had consequences for both the migrants and the nonmigrants, the institutions and social structures of both the sending and the receiving communities (Ploski and Williams 1989, p. 469). From the start, there were impacts on housing and public health, social and political conflicts, racial unrest, job discrimination, employment and recreational shortages, and increases in self- and group-destructive behaviors. By the late 1960s, the urban centers that initially attracted African Americans with promises of economic opportunities for social and political advancement actually experienced a variety of unanticipated pressures.

During the 1970s, the rural-to-urban trend slowed markedly. The number of outmigrants decreased substantially, and others who had outmigrated returned to the rural South. Many northern-born African Americans also moved to the South in response to job openings and a change in political and social relations in many areas there.

Although rural-to-urban migration continued through the 1980s, the period also brought a new pattern of redistribution for African Americans. The trend during this decade was highlighted by movement away from inner-city urban areas to metropolitan suburban areas. It also signified the movement away from central cities of metropolitan areas. This pattern had a significant impact on the overall distribution of the African-American population. For many years, the proportion of African Americans living in central metropolitan cities steadily increased, but from 1970 to 1980 it began to decline. In 1970, 58.2 percent of all African Americans were living in central cities; by 1980, the percentage had fallen to 55.7. The growth of suburban African-American populations continues to surpass that of the city populations for this same group (Ploski and Williams 1989, p. 476).

There has also been another significant effect of the redistribution of the African-American population. For the first time, social stratification has proliferated, which has had a pronounced impact on the collective unity of the group. Again, the emphasis on individual achievement and status recognition associated with the mainstream American culture has begun to replace the core values and beliefs traditionally held by the African-American culture. As a result, many of the informal processes for collective survival (i.e., mentoring of elders, intergenerational relationships, interdependency, or extended families and kinship relations) have been severely disrupted.

Population growth and redistribution have been the major results of African-American migration. In the 1980's, the U.S. African-American population had grown to nearly 26.5 million. According to population statistics from 1987, African Americans in America totaled approximately 29,736,000, or about 12.2 percent of all Americans (Ploski and Williams 1989, p. 471). The effects of such growth and of the subsequent population distribution pose challenges for the culture, for public policy, and for social development programs.

Although many African Americans have made enormous strides in being able to participate in and contribute freely to the stabilization of the collective and to the broader society, a major segment of this group has been left behind. "The state of Black America in the 1990's suggests that [the] gains have not nearly been enough; that while half of our people have made advances, the other half are mired in poverty, joblessness, and hardship" (Jacob 1990, p. 8). There is, however, clear evidence that the African-American culture continues to value group cohesiveness and collective responsibility. This is well demonstrated by the recent mobilization of efforts to reconnect the "haves" with the "have nots" through such programs as mentoring, "Each One, Teach One," Black Family Adoption, and other large-scale, broad-based collective community efforts.

Conclusion

The information presented here regarding the African-American culture in all its diversity and complexity provides some of the insights needed by all professionals who consider themselves responsive to the African-American communities.

> *Ultimate solutions to problems or questions come from examination and correction of causes, not the symptoms. Correction of causes automatically dictates the correction of symptoms. But attacking and eliminating a symptom with a placebo or panacea leaves the cause undisturbed and able to subsequently produce more symptoms. What we are getting to is that in order for "social change" or "betterment of society" or just plain healthy attitudes and behaviors on both personal and group levels to come about where they are missing, we must first change the values of the social structure of that person or group we are talking about (Kunjufu 1972, p. 43).*

Effective interactions with African-American communities require that the broader society, as it develops and implements programming for this group, take into account the prominent aspects of the group's culture. Traditional services have not been mindful of the distinctiveness of targeted populations and of the values and beliefs its members hold dear. In addition, any attempts to evaluate such programming must have a dual acceptability; that is, they must be acceptable to the rigors of scientific exploration as well as to the African-American ethos and worldview. The following chapter will address the crucial issue of program evaluation.

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3

Practical Considerations for Program Professionals and Evaluators Working With African-American Communities

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Abstract

Many cultural and historical factors distinguish African Americans from the rest of American society. These factors, along with social, political and economic realities, significantly influence alcohol and other drug (AOD) use patterns in African-American communities. However, few training programs provide developing health professionals with adequate information about Black culture and history or about the relevance of such cultural factors to the role and responsibilities of the program evaluator. This chapter explores the significance of ethnic identity and culturally defined attitudes for understanding cocultural dynamics in AOD use/misuse prevention programs, and discusses how culture and race influence the various phases, levels, and tasks of program evaluation. As a complement to the preceding chapter, which provides a detailed orientation to African-American culture, this chapter translates theory into

practical recommendations for program administrators and evaluators working with African-American communities.

Introduction

As detailed in the preceding chapter, Africans brought to the United States a unique and highly developed cultural orientation. Classical African tradition contributed significantly to the growth of this country and allowed African Americans to survive and thrive in the face of tremendous adversity.

Although much of the traditional African way of life was threatened and distorted by the experience of oppression, well-established patterns of socially acquired behaviors were and continue to be transmitted from generation to generation of African-American descendants. However, the legacy of slavery and the continuing assault on the personhood of African Americans have necessitated the creation and maintenance of survival strategies that are often confused with and difficult to distinguish from the African-American culture. The resulting confusion complicates the work of program administrators and evaluators in African-American communities.

The purpose of this chapter is twofold: (1) to outline and explore some of the factors that might hinder the work of program administrators and evaluators of alcohol and other drug (AOD) misuse and abuse programs in African-American communities, and (2) to propose solutions. In the process, two basic notions will surface in various forms throughout this chapter. The first is that those who have a stake in the program under evaluation will resist evaluation efforts if the costs of the evaluation are expected to outweigh the benefits. The costs may be economic or social, individual or organizational (LaMar 1991). Where there is conflict of a cultural nature, social costs, which include having to change deeply held values or having to go against group norms, are often of great concern. The second notion that appears frequently in this chapter is that there will be less resistance to evaluation efforts if those who have a stake in the program being evaluated are meaningfully included in and have some sense of ownership of the evaluation process.

While reading the suggestions and strategies discussed below, it is important to keep in mind the diversity within the African-American community. One reflection of that diversity is the use of the terms *African American* and *Black* to refer to the target group. *Black* appears in upper case to denote ethnicity rather than only race; *White* appears in upper case for the same reason. *African American* is used to refer to Black people who are descendants of men and women brought to the United States as slaves, whereas *Black* is used to represent all people and cultures of African descent, including—but not limited to—Black people from the West Indies, Africa, and the Americas. At times, the two terms are used interchangeably for greater readability.

Some of the suggestions and strategies discussed here may be more relevant for some subgroups than for others. In some instances, when socioeconomic status and education are controlled for, there are fewer behavioral differences among subgroups of African Americans and members of other cultural groups than might be expected.

This chapter is not intended to serve as a cookbook; such an approach does not do justice to the complexity of the issues at hand. To place into context some of the practical suggestions contained herein, it is recommended that the reader consult the preceding chapter, which describes the key aspects of African-American culture and community in detail. The development of a valid description of the phenomenology of being African in the United States has been hindered by a tendency on the part of social scientists to view African Americans as a monolithic group, by active denial and distortion of their accomplishments, and by their tendency to focus on the limitations rather than on the strengths of their culture and their community.

Black people and White people have been segregated socially, economically, and educationally since African Americans were brought to this continent hundreds of years ago. The segregation has provided too few opportunities for meaningful cross-cultural exchange and understanding between the two groups. Thus, the complex and sensitive relationship between African Americans and European Americans has had several byproducts, including destructive myths, stereotypes, and attitudes regarding both Black people and Black culture and its symbols, as well as resentment and mistrust of White people on the part of many Black people.

Moreover, White people and others are socialized directly and indirectly to fear and devalue African Americans (Dennis 1981), attitudes that can potentially undermine working alliances in cross-racial settings. It is very difficult to be socialized into this society without being presented with myriad opportunities to internalize negative beliefs and attitudes about those who are not members of the dominant culture. No professional group—including evaluators of and professionals in community-based AOD prevention and treatment programs—is immune from the infectious influence of racism. Further, few training programs equip their developing professionals with the information and understanding that are relevant to the communities they serve. This would include knowledge about the history and culture of the community, attitudes that are consistent with respect for and appreciation of cultural differences, and skill in communicating with members of the host community.

Evaluators and program administrators of community-based AOD treatment programs in African-American communities need to bring to their roles a more than rudimentary understanding of the dynamics of racism, an awareness of their own cultural baggage and of how it affects their work roles, and some basic knowledge of traditional values and behavioral codes prevalent in African-American communities. Moreover, the knowledge, attitudes, and skills mentioned above are crucial to the effective design implementation and evaluation of community-based programs. For a program based in the African-American community, this would require that the program design take into account current realities of African Americans; use accurate knowledge about the complex social and economic structure of the community; make use of available community resources; guard and mobilize the positive forces in the community; and in no way threaten the integrity or survival of individuals, groups, or institutions that promote the community's well-being.

Few of the evaluators of community-based drug treatment programs in African-American communities are African American; yet many of the programs are staffed with significant numbers of African-American professionals, paraprofessionals, and other workers. These different cultural groups often bring to the organization different cultural frames of reference. There is no substitute for direct experience with persons who are culturally different when it comes to shaping perceptions of and attitudes about those persons.

However, experience alone is not sufficient. The information we bring to intergroup contacts is a powerful determinant of how that experience—and, as a result, the people involved—will be appraised (Brislin 1983). This chapter is intended as a supplement to direct experience. It represents an attempt to add to the limited pool of information about strategies and resources for professionals working in AOD misuse and abuse prevention and treatment programs in African-American communities.

Overview of the Problem

The myriad social problems that result from racism and discrimination, along with the widespread tendency to use chemical substances to cope with resulting frustration, have contributed to the development of a national AOD problems epidemic (Musto 1990; Primm 1990). Inner-city communities, which are tantamount to foreign territory for many professionals in the field of AOD misuse and abuse, are among the hardest hit (Baker 1987). These communities are home to a significant number of African Americans.

Understanding cultural norms, values, and behavioral codes increases an evaluator's ability to collect, analyze, and disseminate accurate and useful information. However, knowledge of different cultures and multicultural competency are not easy to achieve for evaluators who were socialized into an ethnocentric Western perspective and are products of training programs that provide little orientation to cultural issues.

Traditional approaches to evaluation focus on quantitative data and statistical analysis. They yield technical reports that are often not understandable by or even made available to the agencies studied. In addition, these approaches often promote a separation between the evaluator and the program being evaluated. An assumption that is consistent with the traditional paradigm is that it would be unscientific to involve staff to any great extent in planning and conducting the evaluation (Alderfer 1977). When the process is approached in this traditional manner, evaluation is something that is done to and not in cooperation with the community organization. Therefore, the evaluator or evaluating team is responsible for determining the approach and carrying out the evaluation plan while the organization's staff simply complies with requests for information and waits patiently for results. Such an approach typically produces tensions between the two groups, resulting in poor communication and other factors that impede the process of the evaluation.

In general, traditionally trained evaluators, like many other researchers, place a great deal of importance on the objective, logical, rational aspects of phenomena. Consequently, they tend to mistrust the emotional and nonquantifiable and to value highly the printed word. These factors, which reflect the particular cultural frame of reference being brought to the task, are significant in determining what is measured, what methods are used, and how the results are interpreted. Similarly, the dominant culture stresses such values as independence and competition and promotes a preference for the objective over the subjective in scientific inquiry. These and other cultural values play a significant role in the selection of program goals, the approaches to evaluation, and the identification of variables to be examined. However, these values often clash with those promoted in African-American communities. In general, African-American culture encourages interdependence and cooperation and finds more merit in subjective experience, values and behavioral codes that have been linked to the ability of Black families to survive in the face of adversity (Gay 1987).

Use of Illicit Drugs in the African-American Community

The use of chemical substances in a cultural group or in society is a cultural phenomenon, the significance of which must be understood before effective programs can be designed and evaluated. However, a comprehensive understanding of AOD use patterns in the African-American community has been hindered by the paucity of information that exists about middle-class African Americans who have little contact with public agencies. In addition, limited attention has been paid to within-group differences among members of the Black community in the use of illicit drugs. Kleinman and Lukoff (1978), in a study comparing native African Americans with West Indians, demonstrate differences between the two groups in receptivity to peer influences. Their work underscores the importance of exploring ethnic differences in Black samples.

With respect to the use of alcohol and other drugs, however, there are common themes that link subgroups of African Americans. In general, social stratification, church and community involvement, and racial identity are thought to be important variables in attitudes toward AOD use in the African-American community (Gary and Berry 1985).

Although African Americans have been observed to drink less and have lower levels of drug use than some other ethnic groups (Hartford and Lowman 1989; Herd 1985; Welte and Barnes 1987), the use of illicit drugs is nevertheless a major problem in the African-American community. One reason for this is that those African Americans who use alcohol and other drugs experience higher rates of AOD-related health problems than do users from other ethnic groups (Herd 1989). In addition, many members of the African-American community cannot easily protect themselves from the indirect effects of AOD abuse, such as homicide (Harper 1978). Also, African-American youth show higher rates of combined use of alcohol and other drugs than do White and Latino youths (Welte and Barnes 1987) and face more economic and cultural barriers to AOD treatment (Lonesome 1985/86). These trends suggest a need to use multiple data sources and to examine culturally relevant but often neglected variables in program design and evaluation research.

Using a Multisystems Approach to Evaluation

The community-based AOD treatment program is one component of a system in a dynamic relationship with other components or subsystems. An awareness of both the external and internal pressures that interfere with achieving the stated goals of the program being evaluated contributes to a more valid assessment of the program's overall functioning.

Frequently, community-based programs in the African-American community are administered from the outside. The funding sources and directives are external. The external agency thereby takes on a parental quality, and the evaluator, as an agent of the external agency, becomes an authority figure. This can undermine any perception of the program's support for community values and thus become an additional source of stress on the system.

Moreover, many of the programs based in the African-American community take on some of the characteristics of the individuals and the larger community they serve. They try to function in the face of limited resources, excessive demands, and too great a dependence on external sources for resources. Frequently, grassroots members of the Black community who are employed as program staff have limited personal financial resources. Many may have additional jobs for needed extra income. The evaluation process may create demands for time and energy that are difficult to meet. To avoid the resentment this might engender, evaluation activities that are redundant, questionably related to program objectives, or too demanding of resources should be identified and eliminated.

Phases of Evaluation and Implication

Staffing the Evaluation Team

The evaluator often plays a marginal role relative to others who are involved with the program. This is the case even when maximum participation of program staff is encouraged during the evaluation process. The term *evaluator* creates a measure of separateness. When there are cultural differences, often the barriers increase as the evaluator is viewed as even more of an outsider. The presence of a member of the dominant group—if this person is viewed as unsupportive of the community's values—may be seen as a threat to the survival of the organization. And the more power the person has, real or perceived, the more threatening he or she becomes.

In many cultures, the age, race, sex, and credentials of the evaluators may have a significant impact on the evaluation process. It is in this regard that two values associated with African Americans are important: respect for authority and respect for the wisdom that comes with age. If the values of a community-based agency are consistent with these traditional values, then—all things being equal—the most influential and respected members of the evaluation team are likely to be older individuals with academic credentials related to their expertise as evaluators.

At the same time, every effort should be made to include African-American evaluators who are positively identified with the Black community among the members of the outside team. However, racial similarity should not be the only requirement considered beyond competency as an evaluator. Many African-American professionals are themselves products of traditional educational experiences and may have little awareness of the realities of fellow African Americans from different socioeconomic circumstances.

The concept of "racial identity" is useful for understanding the nature and impact of racial socialization on the behaviors and attitudes that African Americans and others bring to their work roles. Racial identity refers to a sense of group or collective identity based on the perception of a shared racial heritage (Helms 1990) and to the quality or manner of one's identification with a racial group. We are socialized to have a particular understanding of what it means to be a member of a certain racial group in this society and to have positive or negative attitudes about members of outgroups.

Helms (1984) developed a model of White racial identity. She described the manner in which White people move from being ignorant about people of color and what it means to be White in America, to a position of harboring conflicting or negative views toward persons of other races and an idealized perception of White people, to the healthiest position of accepting and valuing different cultural perspectives.

The Cross (1971) developmental model of racial identity describes differences in the degree to which Black people acknowledge and express comfort about being Black. At lower levels of racial identity, Black people express attitudes and beliefs that are consistent with the idealization of the dominant culture and the devaluation of the African-American culture. Higher levels of racial identity are associated with racial pride, participation in the community and culture, an absence of stereotypical defensive patterns, and a recognition that all cultures have strengths and limitations.

Cross' model can be used to understand the cocultural dynamics that may occur between the host agency and the community-based program professional or administrator. Depending on the nature of the racial identity attitudes that each individual or constituency brings to an interaction, their relationship can be constructive or destructive to the goals of a program or evaluation effort. It cannot be assumed that every evaluator and program professional of color will hold racial identity attitudes that will enable him or her to identify and promote the strengths of other persons of color. The value systems and codes of behavior of both Black and White program professionals and evaluators may clash with those of other members of the community-based organization. Racial identity attitudes that clash are likely to interfere with the development of a constructive working alliance as they become a significant source of stress for all work groups, who consequently respond in ways that hinder the progress of the evaluation and the attainment of program goals.

Some assessment should be made of the racial identity attitudes of those seeking positions as program professionals and members of evaluation teams. Prior experience with community-based agencies and references will provide some information. However, responses to interview questions designed to tap culturally relevant knowledge, attitudes, and skills will probably provide the best indication of a candidate's suitability for the job.

Gaining Access

Access to important sources of information and other resources is a primary concern of evaluators. They need to know where and how to look for information and resources, and how to understand what they have acquired.

Forging a positive alliance with the leadership of a community is one important strategy for gaining access to the community's resources. Joining with trusted and respected members of the community could also enhance the credibility of an outsider as well as facilitate the identification of obscure potential resources. On the other hand, failure to connect with key persons, whether they be formal or informal leaders, could undermine even the most sincere efforts to achieve certain goals.

Some analysis of the formal and informal leadership both within and outside of the community-based organization could be very useful. Extant ethnic/racial organizations such as the church, sororities, and fraternities should be used to achieve AOD misuse and abuse prevention objectives.

It is not always easy to know who the leaders are. Often, the leaders appointed by the funding sources are not regarded as leaders by members of the community. Whereas the funding sources may rely on academic credentials, work experience, or political connections to select leaders, members of the African-American community are much more likely to locate leadership in individuals who have embodied the values of the community, particularly the characteristics of spirituality, wisdom, strength of character, and style, as exemplified by the mother-sister character in Spike Lee's 1989 film, "Do the Right Thing."

Evaluators who are not knowledgeable about African-American cultural etiquette could make serious errors in their interactions with African-American staff members. For example, an evaluator who sees African Americans as cool and laid-back might approach them with a certain casualness that is offensive. Calling staff by their first names without an invitation to do so or dressing very casually might be an attempt on the part of the evaluator to fit in or to create a more approachable persona. However, Black staff, for cultural and historical reasons, may view this behavior as disrespectful and unprofessional.

Trust is also a significant factor in gaining access; where trust is limited, access is difficult to obtain. Because of the long and tragic history of racism in the United States, many Black people have come to question the intentions of White people during interracial exchanges. This has been referred to as "healthy cultural paranoia" (Grier and Cobbs 1968), and it may be important for an evaluator who is trying to gain the support and cooperation of staff. The racial difference alone may be significant enough to provoke healthy cultural paranoia; however, evaluators may have some characteristics that heighten the distrust. The evaluator may be perceived as patronizing or racist if he or she either verbally or behaviorally expresses attitudes that are inconsistent with the culture of the community.

An evaluation process that includes program staff in a meaningful way is less likely to provoke cultural paranoia and is a more efficient way to gain access to needed resources. Staff members can be actively involved in identifying important sources of information of which the evaluator may be unaware and in obtaining such information. Further, an evaluator who demonstrates knowledge of the culture and respect for cultural differences is likely to communicate more effectively than someone who does not possess these qualities and, consequently, stands a better chance of gaining access and developing cooperative alliances.

Problem Definition

Involving community members in problem definition is an important strategy in alleviating evaluation difficulties that arise between the community and the evaluator from differences in language, values, expectations, and behavioral codes.

As suggested previously, members of the African-American community, the community-based agency's staff, and the culturally different evaluator may bring to the evaluation process different frames of reference. These different constituencies may disagree about program goals and objectives as well as about the purpose of the evaluation itself. Consequently, some awareness of different points of view and of the cultural relevance or adaptive significance of target behaviors is essential for accurate problem definition.

Conversely, unawareness of or bias against cultural values that differ from those promoted by the dominant culture might result in the selection of program goals that alienate participants from their culture and reduce their ability to function effectively in their cultural milieu. For instance, one program goal might be to enable Black males to express vulnerability and other feelings as a coping strategy to combat alcohol and other drug use/misuse. Yet program participants might view this as culturally incongruent and as a request to risk the loss of respect by peers.

At one community-based program, conflict between evaluators and agency staff over program goals centered on differences in views toward the legitimacy of increased spirituality as a program goal. Program staff considered increased spirituality to be highly desirable, whereas the evaluators viewed it as excessive religiosity and a symptom of significant psychological regression among the staff. As a result, too much time and other program resources were devoted to managing this conflict, and the evaluation did not proceed in a smooth and cost-effective manner.

Lack of awareness of, and appreciation for, cultural differences could also result in erroneous assumptions about organizational functioning and program outcomes. For example, African Americans are inclined to incorporate music, dance, art, and spirituality into their daily activities and to use time flexibly (Nobles 1986). This clashes with a tendency in the dominant culture to associate art with leisure and to view the flexible use of time as undisciplined. Thus, what might indicate well-being and cultural identification to an African American might indicate dysfunctional behavior to a White evaluator.

A similar value conflict relates to differences in how time is perceived and used, as evidenced by the continuing presence of early African tradition in the way many Black people think about time. Time is marked by major events—births, deaths, marriages—that repeat themselves throughout the life cycle. Consequently, time is cyclical in nature (Nobles 1986). Behaviorally, this is manifested by a more flexible use of time, with less rigid adherence to time boundaries and punctuality. Thus, for many African Americans, time is not limited and should be used for emotionally satisfying, fun activities. But in the linear system that is characteristic of American and many other Western cultures, time is often precisely measured and is oriented toward work, future, and money (White 1984). Thus, statements like "time is money" and "idleness is the devil's workshop" have a great deal of significance for those who, like generations of American children, were taught the Protestant work ethic.

Given this difference in perception, use of time might be an unreliable or misleading variable for assessing the organizational functioning of programs that employ or service significant numbers of African Americans. Conflicts involving time are avoided when community members and program staff join outside evaluators in deciding "when" the evaluation or certain evaluation activities should take place. It is often helpful to build in some time for arrival and social interaction before moving to the business of a scheduled activity. In fact, scheduling in 15 minutes for refreshments at the beginning of a session could even facilitate the process of getting started.

Culturally Sensitive Measures

Lack of information about the cultural characteristics of the group being studied and lack of appropriate program goals are often factors in the failure to choose appropriate instruments with which to measure program effectiveness. Some of the most popular assessment tools may not be appropriate for use with African-American populations, given that the groups on which some of these measures were normed may have characteristics that differ significantly from those of the target populations under study. Moreover, many of the commonly used instruments, such as measures of self-esteem, decisionmaking abilities, and other person-centered traits, imply that the aberrant behavior is the fault of the individual (Payton 1981). Such measures do not assist the evaluator in determining the role of racism, oppression, and systems dynamics. Thus, program assessment should tap all the relevant aspects of experience, and instruments should be pilot tested to gain valuable information about their suitability. The most appropriate measures would be those that have been normed on populations of African Americans. More informal evaluations that tap program participants' functioning in their natural environments and take into account the adaptive significance of behavior might be used.

Interpretation and Dissemination of Results

Recording observations is only one part of the evaluation process. Making accurate sense of the data is another and one that is perhaps more difficult in settings where evaluators and program staff represent different cultural groups. As has been suggested frequently in this chapter, the meaning or purpose of behaviors may differ from culture to culture, and the possibility of misinterpreting important target behaviors is a serious threat to the outcome of an evaluation. Therefore, it is recommended that community representatives assist in the interpretation of data. These representatives, who could bring to the task a keen understanding of cultural norms, values, and behavioral codes, should serve in an advisory capacity. They should be able to examine data for cultural relevance and assist in interpreting outcomes in a cultural context.

The manner in which the outcome of an evaluation is presented is of paramount importance. A major problem with published accounts of the status of the African-American community is the tendency to skew the picture negatively. Strengths are often not highlighted and negative stereotypes are often reinforced. One way to address this tendency is to involve community representatives in decisions regarding the content, format, and dissemination channels of reports detailing the outcome of evaluations.

Using knowledge of African-American communication channels can greatly facilitate the feedback process. The sharing of evaluation results can be accomplished through dramatizations, mural magazines (information sheets posted in public places), music, dance, community forums, Black radio and television programs, or the use of more traditional means such as formal presentations (Brunner and Guzman 1989).

Information pertaining to prevention and the outcome of community-based program efforts should be accessible to all concerned, particularly the residents of the community. If it is not, the program and evaluation efforts fail to achieve what is perhaps the most important goal—to benefit the community.

Conclusion

The design and evaluation of AOD misuse/abuse prevention and treatment programs in African-American communities are political, social, and cultural events. Therefore, the political, social, and cultural needs of those who have a vested interest in such programs must be considered. Because of the unique history and culture of African Americans, program professionals and evaluators need to be knowledgeable about and respectful of the African-American worldview if they are to achieve their program goals. Approaches that do not promote the values and integrity of the host community are likely to be resisted, if not completely undermined.

Evaluation must be viewed as a key aspect of the overall design of programs, not as an afterthought. To facilitate access to valuable community resources, including human resources, and to assess program and evaluation outcomes accurately, a planning and review committee with representatives from the African-American community should be established early and used.

Where there is cultural congruency and genuine inclusion of the community in running and evaluating programs, program professionals and evaluators will have access to a wider array of resources; will find communication to be more open, efficient, and productive; and will encounter less resistance to their work. Moreover, program outcomes and evaluation findings will be more relevant and useful to all concerned. Based on what has been said in this chapter regarding the factors that hinder or facilitate the work of program administrators and evaluators of AOD abuse prevention and treatment programs in African-American communities, program professionals and evaluators should

- establish an evaluation planning and review committee with representatives from the host community;
- invest time in learning about African-American history and culture;
- find out what questions need to be asked and what methods are appropriate to the community and culture of the organization;
- use multiple data sources, including key figures in the African-American community such as family members, schools, clergy, spiritualists, heads of sororities and fraternities, and other more informal leaders; and
- identify and use appropriate channels in the community to disseminate evaluation results.

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A Culturally Sensitive Model for Evaluating Alcohol and Other Drug Abuse Prevention Programs: A Hispanic Perspective

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Abstract

This chapter seeks to increase the understanding of demographic, sociocultural, and psychological variables that need to be taken into consideration when evaluating alcohol and other drug misuse and abuse prevention programs earmarked for Hispanic communities. To this end, this chapter first defines and describes a comprehensive evaluation process that he believes to be most appropriate and effective for use in evaluating such programs. Second, to exemplify how such a process can be feasibly carried out, it presents an implementation model, which is then used to show how Hispanic demographic, sociocultural, and psychological characteristics can and should be considered in the evaluation process.

Introduction

In recent years, researchers and social program developers have directed a significant amount of attention to the high prevalence of alcohol and other drug (AOD) misuse/abuse among certain Hispanic subgroups. This attention has resulted in an increase in the number of studies designed to understand the factors that contribute to the prevailing patterns of AOD use in diverse Hispanic communities. Concomitant with the increase in research, although not always reflective of the findings emanating from it, has been the increase in the development and implementation of AOD use or misuse prevention and treatment programs in targeted Hispanic communities. And with these two trends, relevant program funding agencies (e.g., the Office for Substance Abuse Prevention [OSAP]) and some preventive program developers have realized (as evidenced in the focus of this book) that an accurate and meaningful evaluation of any preventive program earmarked for a Hispanic community must take into consideration (1) those demographic, sociocultural, and psychological characteristics that differentiate the Hispanic populace in general from the White middle-class populace, and (2) those characteristics that differentiate the diverse subgroups that compose the heterogeneous entity encompassed by the term *Hispanic* and that are so aptly described by Padilla and Salgado de Snyder in this volume.

The goal of this chapter is to help program evaluators increase their understanding of selected demographic, sociocultural, and psychological variables that need to be considered when designing and implementing a comprehensive evaluation process relative to AOD use or misuse prevention programs earmarked for specific Hispanic communities. Underscoring this goal is the belief that failure to consider such variables will only result in inaccurate or misleading interpretations and conclusions about the success or failure of such prevention programs, in part or in total.

However, before directing attention to such variables, it is necessary to define and briefly describe a comprehensive evaluation process that I believe to be most appropriate and effective for use in evaluating preventive programs earmarked for the numerous Hispanic communities at the lower end of the socioeconomic and educational spectrum. To exemplify how such a comprehensive process can be carried out within a preventive program, I present a model that can facilitate such implementation. This model serves as the vehicle to demonstrate how the demographic, sociocultural, and psychological characteristics addressed by Padilla and Salgado de Snyder in this volume should be taken into consideration in a comprehensive evaluation process.

To meet the goals and objectives of this chapter, I think it necessary to underscore the two basic premises put forth by Padilla and Salgado de Snyder: The first is that the Hispanic population is not a unitary ethnic group. On the contrary, this group is quite heterogeneous, composed of "subgroups that vary by Latin American national origin, racial stock, generational status in the United States, and socioeconomic level." The second is "that, although there are communalities that have been well summarized in the literature describing the Hispanic culture (e.g., the Spanish language, Catholicism, family orientation," and respect for elders and persons in authority), many of these cultural attributes are continually undergoing modification as a result of acculturation. (See p. 118 in this volume.)

Given these two premises, the competent evaluator is challenged to understand and "appreciate intragroup variability as much as intergroup diversity" (Padilla and Salgado de Snyder, this volume, p. 118). Having said this, I now alert the reader to the fact that, although in this chapter, for the sake of succinctness, I use the generic term *Hispanic* when discussing characteristics and issues that may be applicable and relevant to a significant number of Hispanic subgroups, these characteristics and issues may not be applicable and relevant to some specific Hispanic subgroups. Thus, when in doubt or for the sake of accuracy, the reader—the potential evaluator—is cautioned to seek out further information from knowledgeable sources (Hispanic leaders in targeted communities, research literature, etc.).

Finally, it should be noted that, like Padilla and Salgado de Snyder (this volume), I do not ascribe to the belief that in a few pages I will be able to provide an "outsider" with all the necessary information and sensitivity vis-à-vis Hispanics that an "insider" might bring to the process as second nature. Instead I intend, like the aforementioned authors, to highlight selected information that will help evaluators understand and appreciate the depth of cultural knowledge about Hispanics that they need to have in order to formulate relevant and appropriate questions, hypotheses, and procedures that are more in line with the insiders' base of knowledge, understanding, and experience.

Defining a Comprehensive Process for Evaluating Preventive Programs in Hispanic Communities

Prevailing negative employment, socioeconomic, and educational conditions in many Hispanic subgroup communities (see Padilla and Salgado de Snyder in this volume) may require that preventive programs earmarked for such communities incorporate an evaluative process that is much more intense, dynamic, and comprehensive in nature than the processes that have historically been used in traditional White middle-class communities so as to increase the programs' probability of success. Such a process is briefly defined and described here.

The evaluation process toward which attention is directed here is essentially that provided by Price and Smith (1985) in a document entitled *A Guide to Evaluating Prevention Programs in Mental Health*. According to these authors, program evaluation is the systematic collection, analysis, and interpretation of data to determine the value of social policies or programs; such data will be used later in decisionmaking relative to that policy or program. In presenting this very general definition, Price and Smith are quick to differentiate program process evaluation from program outcome evaluation, the type of evaluation with which most social scientists, government funding agencies, and community program developers are most familiar.

According to Price and Smith (1985), program process evaluation seeks to generate information that is useful to ongoing program planning, development, and administration. Such information is extremely important to those Hispanic subgroup communities that have had little or no experience in developing and implementing prevention programs of any kind. In contrast, program outcome evaluation seeks to determine the effectiveness and, in particular, the cost-effectiveness of program models, and it frequently tests theories of prevention. Program process evaluation describes program accomplishments, processes, and problems, whereas program outcome evaluation tends to focus primarily on the potential effects of new policies or programs. Program process evaluation serves as an integral part of rational program management and accountability, reducing—but never quite eliminating—uncertainty in decisionmaking relative to day-to-day operations and long-term planning. In a nutshell, one could say that program evaluation documents and measures the efforts extended to attain the short- and long-term objectives inherent in the program from a noncritical perspective.

Ideally, with the characteristics noted above, program process evaluation can provide the type of feedback that can be used to strengthen ongoing programs; this can enhance their ultimate effects and, in so doing, increase the probability of obtaining positive results in subsequent program outcome evaluation efforts. The fact that I choose here to emphasize strongly the importance of program process evaluation, as described above, should in no way be interpreted as downplaying the importance of program outcome evaluation. On the contrary, such evaluation is tremendously important for determining the programmatic- and cost-effectiveness of the prevention program. However, it is the type of evaluation that, as noted previously, is most familiar to relevant evaluation agencies and program personnel, and, as such, it is only briefly addressed in this chapter. The reader who would like additional information on either type of evaluation should refer to Rossi and Freeman (1989).

In summary, the importance of using a comprehensive evaluation process that incorporates both program process evaluation and program outcome evaluation is underscored by

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the fact that such incorporation enables preventive programs earmarked for Hispanic communities to

- increase the chances that the targeted Hispanic community will receive services that will improve over time, as evaluation information is fed back to the program and adjustments are made in its delivery;
- provide the opportunity to discover additional unanticipated benefits and/or negative effects associated with prevention efforts;
- help program personnel determine if they are actually reaching the population with whom they are concerned in the community; and
- enable program staff and administrators to provide pragmatic, comprehensive, and effective descriptions of the program that can be used by other interested practitioners who may wish to develop similar programs in their own communities (Price and Smith 1985).

Addressing Selected Hispanic Characteristics in a Comprehensive Process for Evaluating Prevention Programs in Hispanic Communities

To exemplify how a comprehensive evaluation process might be implemented in the context of a preventive program, a three-phase action model is presented. The three phases that compose this model are

- Preparing for Action
- Taking Action
- Evaluating Action

To facilitate implementation of the model, I have identified the specific steps inherent in each phase. These steps are, in turn, used to provide the structure from which to identify selected demographic, sociocultural, and psychological variables that must be carefully considered when evaluating preventive programs earmarked for Hispanics.

Phase I: Preparing for Action

Phase I of this comprehensive evaluation model comprises the following four steps:

- ♥ Developing an understanding of the total program development and comprehensive evaluation process.
- ♥ Nurturing community support for the total prevention program.
- ♥ Gathering and reviewing information relevant to the targeted Hispanic community.
- ♥ Assessing prevailing needs and risks.

For the sake of organization, these steps are presented sequentially; however, in applying the model, the actions contained in these steps often occur simultaneously.

Developing an Understanding of the Total Program Development and Comprehensive Evaluation Process

The initial step in Phase I focuses on the need to have evaluators, program directors, and staff get an overview, understanding, and appreciation of the actual program development and comprehensive evaluation process. More specifically, they need to understand all the planning steps that must be taken prior to implementing any preventive program efforts. And they need to take the time to identify short- and long-term goals and objectives as well as all the intermediary steps necessary to increase the probability of attaining the desired objectives.

With respect to evaluation, it is most important that evaluators help all relevant personnel understand the nature of the comprehensive program evaluation process and how this process can help increase successful program outcomes. Major emphasis must be given to developing the understanding that program evaluation is an ongoing and dynamic process that occurs throughout the life of the program, not just a terminal act that occurs at the completion of the program.

Although developing an understanding and appreciation of the program development and comprehensive evaluation process is extremely important, it can also be quite a challenging and formidable task for evaluators working in low-income, inner-city, Hispanic communities, which most frequently are the Hispanic communities with the worst social and health problems. One of the first major challenges evaluators face when working with such communities, in which economic and service resources are fairly low, is having to justify their existence. In other words, most often, such communities want to know why money that could be used to provide much-needed services is being spent on evaluation. Evaluators must understand and respect this perspective while, at the same time, be prepared to explain their role nondefensively. Such an explanation should emphasize, with a great deal of specificity and examples, what a comprehensive evaluation process (including the planning phase described above) can do to help make the program more cost-effective while also helping to increase the probability of attaining desired outcome objectives and, in turn, increasing the likelihood of maintaining current funding and obtaining future funding for the program.

Another challenge evaluators must face early in the planning process is the pervasive level of mistrust and discomfort that the targeted Hispanic community may hold toward evaluators who may be perceived as "outsiders"—that is, not from the same community; probably not from the same racial, ethnic, or socioeconomic group; and representing the establishment. Although one would like to think that such feelings no longer arise, the fact is that they do, and they arise not precociously but as a result of past interactions that many Hispanic communities have had with both social scientists (e.g., evaluators) and government agencies as a whole. More specifically, it has been well documented by various ethnic/racial researchers (e.g., Casas and Thompson 1991; Gordon 1973) that mainstream social scientists have tended to enter ethnic/racial communities, collect their data, and then leave without providing any pragmatic feedback about their findings and, more important, without ever taking any visible actions based on their findings to benefit these communities substantively. In a similar vein, most government agencies and personnel are viewed with suspicion, given their running record of failing to provide relevant and sufficient services to Hispanic communities, or, more closely tied to evaluation, of providing such services until "outside" evaluators conduct a sterile outcome evaluation and determine that a targeted service program is falling short of meeting its objectives and should thus be closed down. Because such perceptions exist in many Hispanic communities, evaluators working within the context of the model described above need to take the time to explain and more effectively exemplify their "helper" role, to help combat and perhaps change prevailing attitudes and feelings that may impede their comprehensive program evaluation efforts.

To this end, and building on the family-oriented and cooperative sociopsychological nature ascribed to more traditional and less acculturated Hispanics, evaluators working with Hispanics should take steps to develop a more equal, cooperative, and collaborative working relationship. An initial step that could help expedite the development of such a relationship and that would also help counteract any negativity associated with the term *evaluation* is to change the title given to the evaluators from "evaluation team" to "service support providers." It may seem trivial, but such a name change was actually instigated by the program staff and community participants of a preventive community program sponsored by OSAP, and it helped to cement the working relationship between the staff and the evaluators. To this community program, the name change implied that the evaluators were there not solely to evaluate successes and failures but also to provide the kind of ongoing feedback and support that would maximize the probability of successfully attaining desired outcomes.

Of course, changing a name, in and of itself, is not enough to maintain a good working coalition. The change should be reflected in the commitment and actions of the evaluation team. If the evaluation team is called a support service, its supportiveness must be visible and dynamic during the early stages of the program development and evaluation process. In these early stages, evaluators may find it necessary to attend program staff meetings regularly to ensure that the program is getting off on the right foot and staying on track vis-à-vis its goals and objectives. In addition, the evaluators may be invited by the program administrators to attend various community meetings and functions so they can develop a more accurate perception of the community in which the program is operating and provide feedback about efforts to generate community enthusiasm and support for the preventive program.

Evaluators who take the time to develop this familial, cooperative, and collaborative relationship in the first step of the evaluation process will find that their subsequent work in the process is greatly facilitated, increasing the likelihood that short- and long-term goals and objectives will be attained. But despite such positive outcomes, the amount of time it takes to develop a collaborative working relationship with the program and, as noted below, the community dissuades many evaluators from doing so. This is especially true for those evaluators who are evaluating several programs simultaneously. Such evaluators should be encouraged to look for creative and cost-effective ways to develop working relationships across programs. For instance, if the program under evaluation is close to an institution of higher learning, the evaluators might consider employing Hispanic graduate students from selected academic departments (e.g., psychology, sociology, anthropology, education, and public health) as assistants/partners who are responsible for maintaining more frequent and consistent contact with both program and community personnel. Hiring such students not only is cost-effective, but also can provide much valuable training and experience to the students as well as extensive benefits to the targeted community.

Nurturing Community Support for the Total Prevention Program

Whereas the previous step emphasized the need for evaluators to develop a strong cooperative and collaborative working relationship with all program personnel, this step emphasizes the need to develop the same kind of relationship between the program and the targeted community, especially community leaders and directors and staff of other educational and social service agencies. The role that the evaluators can and should play in this particular step can vary tremendously, the deciding factor being the level of familiarity the evaluators have with the Hispanic population as a whole and the targeted community in particular. The greater the familiarity with both entities, the greater the role the evaluators should play in helping program personnel identify and develop those activities that will result in the desired working relationships.

Although the eventual development of cooperative and collaborative working relationships may be of value to preventive programs in any and all kinds of communities, it is extremely important that concerted efforts be extended to develop such relationships early in a preventive program earmarked for low-income Hispanic communities. One major reason for this is that, in many of these communities, social service programs are not very numerous and so any "new" program stirs up a lot of curiosity and possibly even suspicion and distrust. Given the aforementioned distrust that exists in such communities toward anything that might be tied to the establishment, major questions are likely to arise when new programs are launched. For example: Why are they really doing this? What do they really want? What is it going to cost us? Are they really giving us something for nothing?

Another reason focuses on the few social service agencies that do exist and that might be struggling to provide services to groups similar to those targeted by the new prevention program. In this case, such agencies may see the new program as invading their "turf," competing for the same clientele and for the same limited resources that are available to service this clientele.

To prevent or allay such concerns, suspicions, and questions, relevant community leaders and agency directors must be informed of and, if possible, involved in early program planning stages. This could very likely include involvement in writing the grant that might eventually provide the program's funds. The impetus for inducing such involvement should clearly come from the fact that the preventive and treatment needs of the probable target communities are so vast and diverse (see Padilla and Salgado de Snyder in this volume) that there are unique and vital roles for all concerned to play.

To generate ongoing community support for all aspects of the preventive program, including evaluation efforts, the program at its initial stage should establish an advisory board that represents as many facets of the community as possible (e.g., agencies, schools, businesses, parents, and adolescents). This board should be used for validation, support, and direction throughout the entire life of the program. (Examples of how to use such a board are interspersed throughout the remaining sections of this chapter.)

The types of activities that can be used to engender both agency and community support are only limited by the level of creativity and energy of both the evaluators and the program personnel. One activity that merits serious consideration is that of launching the preventive program into the targeted community through a one-day conference on AOD misuse/abuse sponsored and organized by the program in collaboration with other social service agencies. The successful implementation of such a conference could provide an excellent way to identify the mechanisms for establishing a collaborative working relationship between all relevant agencies—the kind of relationship that will facilitate the attainment of all program goals and objectives.

Gathering and Reviewing Relevant Demographic Information and Research

Before initiating any program activities, evaluators and program personnel must become very familiar with the community for whom the program is being developed. To this end, evaluators must take the necessary steps to seek answers within the confines of the targeted Hispanic community to such questions as the following:

What Is the Racial/Ethnic/National Makeup of the Community?

The answer to this question may not be as simple as one might think. In seeking an accurate answer, evaluators must remember that the Hispanic population is representative of the following races: Caucasian, Mongoloid, Negroid (i.e., African American), or, depending on the ethnic/national subgroup, various combinations of these. For instance, Mexican Americans can range from pure Mongoloid (i.e., American Indian) to almost pure Caucasian or any point in between. According to Longres (1974) as cited by Padilla and Salgado de Snyder (this volume), at present most Puerto Ricans claim both African-American and White origin (p. 124) and, given their history, Cubans also encompass the full range of genetic makeup from White to African American (p. 125).

How Do Persons From Diverse Ethnic/National Hispanic Subgroups Differ From One Another? How Are They the Same?

Given the tremendous heterogeneity that exists in the Hispanic populace, obtaining answers to these questions may be quite challenging. Although, as noted, many factors tie Hispanics together, including the Spanish language, reliance on the family as the significant social structure, interpersonal style of interacting (e.g., *personalismo, respecto,* and *dignidad*), and the Catholic church, many other factors serve to differentiate Hispanics; these include social, historical, and national factors as well as life experiences. (For further details, see Padilla and Salgado de Snyder in this volume.)

The commonalities and differences can vary greatly from one Hispanic community to another. Consequently, evaluators are advised to be cautious about making any generalizations regarding those commonalities and differences that are often mentioned in the literature. Instead, for the sake of accuracy, evaluators should be prepared to take the time to identify and examine those commonalities and differences that actually exist within their targeted community.

What Is the History of the Targeted Hispanic Subgroup?

Is the targeted subgroup mainly composed of recent immigrants, first-generation immigrants, second-generation immigrants, or a mixture of each? Given that a group's history helps define its national identity, social structures, and even prevailing social problems, it is most important for evaluators to understand that the answers to these questions will vary greatly across the various Hispanic subgroups. For instance, the American Indian and Spanish forefathers of many Mexican Americans were here in the Southwest before this country was founded; other Mexican Americans are first-, second-, or third-generation citizens. Mexican immigrants continue to enter this country in search of better socioeconomic living conditions. Second- and third-generation mainland Puerto Ricans can be found in all major northeastern urban areas. However, it should be noted that, contrary to popular belief, Puerto Ricans are not immigrants in the true sense of the word and, regardless of where they live, are all American citizens.

If the Subgroup Is Composed of Immigrants, Why Did They Leave Their Native Country? More Specifically, Did They Leave Voluntarily or Involuntarily?

According to Padilla and Salgado de Snyder (this volume, p. 133), "Voluntary emigrants are generally seen as adapting more readily to their adopted country than involuntary emigrants or refugees." Accordingly, it should be noted that Cuban immigration to the United States occurred in several phases, starting in 1959 and ending in 1980. Most Cuban emigrants were forced to leave Cuba as a result of political upheavals that occurred after Fidel Castro took power.

As evident in the chapter by Padilla and Salgado de Snyder (p. 126), Central Americans represent the most recent group of newcomers from Latin America to the United States. Furthermore, most of them emigrate involuntarily for several reasons, including extreme economic hardship coupled with the political turmoil that threatens most sectors of Central America.

The history and the rationale behind each subgroup's immigration to this country can greatly influence the nature and scope of both the preventive program and the evaluation process that is developed for a particular subgroup or a combination of subgroups. A preventive program earmarked for third-generation inner-city Puerto Ricans would need to be quite different from one earmarked for migrant Mexican-American farm workers. Similarly, a program directed at immigrants who were forced to flee their country and who may be suffering with posttraumatic stress disorder (PTSD) would need to differ from one directed at immigrants who voluntarily came to the United States to improve their socioeconomic lifestyle and who may very likely relocate in an area of the United States where friends and relatives are already established.

If Recent Immigrants Comprise a Significant Portion of the Targeted Hispanic Populace (For Relevant Statistics, See Padilla and Salgado de Snyder in This Volume), What Is the Likelihood That They Are in This Country Illegally?

The answer to this question could have tremendous ramifications with respect to the types of problems that might need to be addressed. According to Padilla and Salgado de Snyder (this volume), documented immigrants "have an easier time adapting to a new country because their presence is sanctioned and they are granted all privileges of legal status (p. 133)." In contrast, undocumented immigrants, which describes a great many newcomers from Latin America today, may have to cope with and adapt to an often hostile environment. Because they have no legal rights in the United States and can be deported if apprehended, undocumented immigrants are the least likely to seek public services (p. 134). Yet, as emphasized by Padilla and Salgado de Snyder, because of their precarious situation, they may quite likely find themselves plagued with a significant number of stressors. The challenge for evaluators (especially in the area of needs assessment) and program developers is twofold: (1) to get information unobtrusively on the documentation status of their targeted community to develop a more accurate understanding of the type of stressors that, for some individuals, could affect AOD use patterns; and (2) to help develop an effective mechanism to reach and thereby provide needed services to undocumented individuals.

Are the Persons Who Are Likely To Be Targeted by the Preventive Program Staunchly Traditional, Somewhat Acculturated, or Highly Acculturated?

The needs, expectations, availability of social support systems, and, as is evident in the information provided by Padilla and Salgado de Snyder (this volume), the actual pattern of AOD use may vary according to the generational level or level of acculturation of the targeted Hispanic community. These factors must be taken into consideration very early in the evaluation process.

A more basic question would be, *are the evaluators at all familiar with the acculturation process and the impact this process can have on the social and psychological adjustment of Hispanic individuals and families?* Although acculturation has long been acknowledged, especially in the literary field, as a process that affects all immigrant groups as they move toward becoming "Americanized," it has only been recently, with the upsurge in the number of racial/ethnic immigrants, particularly Hispanics, that the process has received serious attention from social scientists. As a result of this attention, it is now apparent that the acculturation process is much more complex than originally thought (Padilla 1980). Furthermore, it has the potential for creating social and personal conditions that are stressful and problematic, conditions that can strongly influence AOD use patterns. Evaluators must fully understand the process and, from an assessment perspective, be familiar with the measures (i.e., instruments) that can be used to assess the level of acculturation of the targeted individuals in the preventive program. The importance of assessing the level of acculturation cannot be overestimated: failure to understand and assess the acculturation level can greatly weaken the entire evaluation and programmatic process.

Additionally, the need to obtain answers to the following questions should be self-evident. What is the social makeup and employment status of the community in general and of potential program participants in particular? What is the mean educational level of the community? What is the level of political knowledge and involvement in the community? Are there identifiable community leaders? What kinds of crimes are most prevalent in the community? Are street gangs prevalent in the community? If so, how do they affect the community? Do the people feel hopeless or hopeful and empowered as to their ability to change their socioeconomic conditions or to tackle and overcome prevailing social problems? What are the quality and status of the social and educational services available to the community? Ultimately, the answers to these questions should give shape to the entire program and evaluation development process.

In the interim, however, the answers should also serve as a guide to help evaluators selectively identify and gather available research-based information, especially that published in professional journals regarding the prevalence of AOD use, misuse, and abuse among diverse Hispanic subgroups, as well as any information about sociocultural or psychological factors associated with specific AOD consumption patterns within these subgroups (see, e.g., the *International Journal of the Addictions*). Evaluators should particularly seek out information obtained from Hispanic subgroups that may be comparable across racial/ethnic, social, historical, acculturative, and socioeconomic factors to the subgroups targeted by the preventive program under evaluation. Ideally, the information gathered should help evaluators expedite their assessment efforts by directing their attention toward specific groups, issues, and conditions that need to be assessed and later addressed in the program's design and implementation. In addition, the research should help expedite the identification of or stimulate ideas for developing specific assessment instruments and procedures.

Padilla and Salgado de Snyder (this volume) present the diverse type of psychosocial research-based information directly related to AOD use among Hispanics that evaluators need to obtain. Some of this and other information is highlighted below to show how such information can be used for programmatic and evaluation purposes. (Further on, socioculturally relevant information and research will be highlighted.)

- Immigrant women show much higher rates of abstention from alcohol and other drugs than do their later-generation counterparts (Padilla and Salgado de Snyder, this volume). Based on such information, preventive programs might offer educational groups that focus on the needs and issues confronting later-generation Hispanic women.

- As stated by Padilla and Salgado de Snyder (this volume, p. 130), because of the social, economic, and cultural conditions defining their lives, many Hispanic women remain in a vulnerable position that places them at risk for developing social and psychological problems, including AOD use, misuse, and abuse (Golding and Karno 1988; Salgado de Snyder 1987). If a major factor associated with these conditions is a lack of education or an ability to communicate effectively in English, the preventive program might work in collaboration with the educational system to provide relevant classes and training at times and places that are convenient for such women.
- Hispanic women are more likely than non-Hispanic women to begin childbearing in their teenage years, which in turn is likely to contribute to the development of various psychological as well as physiological problems for both mother and child (Russo 1985). Having this information, preventive programs might work closely with Planned Parenthood programs by providing culturally sensitive family planning information or by directly establishing some parent support and skill-training groups.
- According to Marín (in press), Hispanic females are less likely than Hispanic males to be found in treatment programs. Should this be the case in a targeted community, the preventive program might direct efforts to developing creative ways to reach Hispanic females. Sponsoring educational and supportive groups in local day-care centers might be a strategy to consider.
- After they immigrate, males change their pattern of drinking to show both high frequency and high quantity (Cervantes et al. 1990/91). Reasons for this change might reflect the lack of immediate family members, who may still be in the country of origin; the lack of an extended family; or the lack of an acceptable support system. Working from this perspective, preventive programs might focus on providing support groups at convenient times and places. To

stimulate attendance, dinnertime might be considered and a hot meal of *menudo* (tripe, hominy, and red chili stew) or *arroz con pollo* (chicken with rice) might be served.

- Immigrant families are often forced to rely on their more acculturated children to interpret and "broker" the world for them. Such brokerage responsibility may require these children to assume adult responsibilities and behaviors prematurely. This, in turn, may increase the level of stress they experience daily. Seeking easy ways to deal with such stress might induce some of these children to turn to drugs or alcohol. Knowing this, preventive programs might be designed to work with schools to provide programs to help children cope more effectively with stress. In addition, they might provide the types of services that the parents have been expecting their children to provide (e.g., translation, filling out paperwork, and making appointments).
- Cervantes and colleagues (1990) found that the major causes of stress "reported by recent immigrants from Latin America are related to occupational and financial concerns (e.g., inability to get a job due to legal status or lack of proper skills, insufficient income to support a family) [and] parenting situations (e.g., overt sexuality in the United States in contrast to the home culture, poor educational opportunities, offspring who adapt quickly and demand independence from their parents like their American peers)" (Padilla and Salgado de Snyder, this volume, p. 136). Given the very concrete nature of these stress-causing factors, preventive programs could work in collaboration with social service and educational agencies to provide educational and support services to help immigrants develop the skills to deal more effectively with these factors.
- Hispanics are currently overrepresented in the number of acquired immunodeficiency syndrome (AIDS) cases compared with their proportion of the total U.S. population (Bakeman et al. 1987). In addition, local surveys of Hispanics have shown that this population is generally poorly informed about AIDS and the human im-

munodeficiency virus infection (DiClemente et al. 1988; Marín, in press). To expedite educational and preventive efforts relative to AIDS, however, programs should not reinvent the wheel. Given the very serious and urgent consequences of AIDS, such programs should turn to existing programs that are successfully dealing with AIDS (e.g., the Minority AIDS Project in Los Angeles) to borrow or adapt existing educational materials and activities for use in their own targeted communities.

- From the perspective of acculturation, Szapocznik and his collaborators (e.g., Szapocznik and Kurtines 1980) have found that Hispanic youngsters acculturate at a faster rate than their parents and that these intergenerational differences in acculturation often result in the disruption of the traditional, closely knit family (Padilla and Salgado de Snyder, this volume, p. 136). According to these researchers, for some families such disruptions result in stressors that can contribute to alcohol and other drug abuse. According to Padilla and Salgado de Snyder (this volume, p. 136), preventive program developers and evaluators should be aware that these researchers have taken steps to develop "specific intervention modalities for Hispanic families experiencing conflicts such as AOD abuse and family disintegration derived from intergenerational and cultural differences among its members" (e.g., Szapocznik et al. 1989; Szapocznik et al., in press).
- With respect to Hispanic youth, researchers such as Padilla and Salgado de Snyder (this volume) are quick to underscore the fact that there is little information on the effects of migration and psychosocial adaptation on Hispanic children and adolescents; thus, an evaluator must be especially cautious when evaluating a program designed specifically for immigrant youth and their families.

Assessing Prevailing Needs and Risks

Once all relevant published research information has been obtained, the evaluators should proceed to collect what I call community-based information and institutional archival information relative to the prevailing needs in the community. Community-based information can be gathered directly from persons who live and work in the community itself; institutional-based information can be obtained from existing reports and data compiled by city, county, and State agencies and offices. Whether such information is community-based or institutional, for some Hispanic communities gathering it can be quite challenging.

Although this chapter focuses largely on the collection of community-based information, a few direct comments about the collection of institutional-based information are necessary. First of all, the kind of institutional archival information that might be of help to both program developers and evaluators could be collected from health, educational, law enforcement, or social service agencies and could include the following:

- From health agencies: blood alcohol levels at time of admission, admissions for withdrawal, emergency room visits, drug overdose admissions, referrals to treatment agencies, hospital admissions data, and incidence of AIDS cases.
- From educational agencies: dropout rate, habitual truancy rate, disciplinary hearings, number of suspensions, number of expulsions, graduation rate, and AOD student surveys.
- From law enforcement agencies: number of persons arrested while under the influence of drugs and/or alcohol, number of drunk driving arrests.
- From social service agencies: number of clients seen with AOD abuse patterns, incidence of women battered by spouse under the influence of drugs and/or alcohol, incidences of child abuse, AOD-related birth-defect children with special needs, and correlations of unemployment and AOD use.

Various factors can impede the collection of such formal data. The four major factors are

- A lack of personnel and other resources to collect the desired data;
- An overabundant and disorganized collection of statistics;

- Data that, for bureaucratic and legal reasons, are very difficult or even impossible to obtain; and
- The lack of specific data on Hispanics or the uselessness of data due to a failure to control for important variables that differentiate the Hispanic populace.

As for gathering community-based information, major challenges include the limited or negative experiences that these individuals may have had with service agencies identified in one form or another with mainstream America; the past negative experiences that certain Hispanic communities have had with government agencies or social scientists who, to obtain desired information, have promised that the information would result in benefits to the targeted community but who have been quick to renege on their promises once the information was obtained or may even have used the information to the detriment of the community (see Casas and Thompson 1991); and a general distrust of any impersonal agency that might seek personal information that the individuals are not accustomed to or are fearful of sharing with anyone (e.g., their legal status in this country, atrocities they may have experienced or seen if they have come from a war-torn country).

To bypass such challenges, depending on the type of information desired, the evaluators should seriously look into gathering the desired information through indirect or unobtrusive methods. To this end, evaluators might consider conducting a service provider survey or making maximum use of the type of institutional archival data noted above (e.g., hospital admits, number of drunk driving arrests). If the use of such methods or data will not suffice, evaluators should then work in collaboration with program staff to develop or identify the most culturally and educationally appropriate needs assessment instruments and procedures that can be used to gather all essential information. Depending on the goals and objectives of the program, the desired information might easily be obtained with short questionnaires developed specifically for the program or, if more extensive and statistically reliable information is needed, with varied standardized questionnaires and surveys.

Regardless of the types and number of questionnaires used, there is some essential information that must be gathered in one form or another (as explained by Padilla and Salgado de Snyder in this volume). Such information includes demographic data (e.g., nationality, level of acculturation, and generational level); the types, prevalence, and severity of existing AOD-related problems (e.g., the use of inhalants among youngsters, the prevalence of AIDS among injected drug users, and the prevalence of PTSD); and the target population's attitudes toward and knowledge and use of relevant preventive and remedial services.

If evaluators decide to develop their own questionnaires and surveys, they should keep in mind that, to maximize the utility and generalizability of the information gathered, they will need to establish the reliability and validity (in particular, the content and face validity) of their instruments. To expedite their efforts along this line, as mentioned previously, they should give serious consideration to establishing an advisory board made up of persons from the targeted population who can give them guidance and feedback vis-à-vis the content, length, language, and cultural appropriateness of the questionnaire or survey. Such a board could also be used to pilot test the questionnaires.

If, on the other hand, evaluators choose to use standardized instruments, they should find out if such instruments have been validated and normed with a Hispanic population or subgroup similar to the one targeted by the preventive program. (For such information, see *The Tenth Mental Measurements Yearbook* [Conoley and Kramer 1989] or refer to empirical studies in which such instruments were either developed or used.) Although few in number, there are some instruments that have been validated for use with specific Hispanic populations. Examples of such instruments that evaluators could use are contained in the appendix.

Given the tremendous variability that exists among Hispanics (see Padillo and Salgado de Snyder in this volume), there is a high probability that validation and norming have not been conducted for the majority of instruments that evaluators might want to use. Thus, evaluators should interpret any information gathered with a great deal of caution and, whenever possible, look to other data (e.g., observational or archival) or to expert sources (e.g., a community advisory board) to substantiate and validate their interpretations.

Whether developing or identifying existing instruments, evaluators should keep in mind the overall characteristics of the targeted population from whom the information is to be obtained. For instance, given the high probability that the targeted population may have a fairly low level of education or may have some degree of difficulty with the English language (see statistics provided by Padilla and Salgado de Snyder in this volume), the evaluators may have to develop or identify instruments with Spanish and English versions that use simple language, appropriate phraseology, and culturally sensitive idioms.

To increase the probability that a significant number of persons will provide the desired information, the format of the instruments should be extremely clear and brief and should allow for easy completion. With this in mind, and to expedite both the gathering and the subsequent analysis of the information, multiple-choice questions with no more than four to five choices should be used whenever possible.

Once the assessment instruments have been developed or identified, evaluators are faced with the overall challenges noted above in reaching the individuals from whom they wish to obtain the desired information and toward whom the preventive program is geared. The evaluators must be aware of and sensitive to the need to address these challenges at all stages that involve obtaining information. As mentioned previously, the greatest challenges may come from efforts to obtain the information directly from the targeted community.

The traditional methods and sources for obtaining the desired information at any and all stages of the comprehensive evaluation consist of an personal/household interview, a telephone interview, a mail survey, and records (archival) data. For the evaluator working with a preventive program earmarked for a Hispanic population, each method—with the exception of accessing records (archival) data—presents a challenge.

Personal/Household Interview

A major challenge associated with the personal interview is the overall lack of familiarity that certain Hispanic subgroups (low income, recent immigrants, traditional) may have with this rather obtrusive method. Standard interviewing methods are derived from European cultural models, which assume that direct questioning is the most effective route to finding out what one wants to know. It is quite likely that these methods may not be as culturally appropriate and effective when used with Hispanic subgroups, who are more traditional in nature and/or come from a low socioeconomic background. To overcome the challenge associated with the lack of familiarity with the interviewing method, evaluators should consider training interviewers to gather such information indirectly, such as within the context of friendly conversation. Unfortunately, if the training is poor and there are no reliability checks, the information gathered by interviewers who use indirect means may be ambiguous and inaccurate.

Given the tumultuous historical backgrounds and precarious living conditions of many Hispanic subgroups, a significant amount of distrust and fear may be engendered by a method that depends on their providing personal and possibly intimate information to a person who is perceived, correctly or incorrectly, to represent an impersonal, government-affiliated office or agency. To overcome this challenge, evaluators may need to launch a public relations campaign prior to beginning the information-gathering process. Such a campaign might involve contacting Hispanic community leaders and agencies and services that are frequented by a significant number of the targeted community (e.g., Catholic Social Services) and asking these entities to publicize and support the planned data-gathering process.

In addition, the evaluators should seriously consider hiring data collectors who are recognized, trusted, and respected members of the community. Prevailing traditional attitudes toward gender roles (in particular, what topics of discussion are acceptable between the genders) might require that pairs of interviewers (a man and a woman) be used when visiting homes to collect data from both husbands and wives. Given the respect that many traditional Hispanics have for elders who have demonstrated their ability to confront and overcome life's problems, the evaluators should also consider using elderly persons to collect information. If evaluators are working with gangs or other special subgroups, it might be advisable to use individuals who, as a result of their personal life experiences (e.g., an ex-gang member who has gotten off drugs and is successfully pursuing his or her life goals), are given high regard or credibility by these subgroups. Furthermore, it is quite likely that, to ensure an adequate number of respondents from such subgroups, the evaluators or designated individuals will have to gather the data on the streets or wherever a significant number of persons from the subgroup are likely to be found (e.g., shooting galleries, bars, and baths). To this end, persons expected to gather the information in such places should be extremely well trained and cautioned regarding *all* the risks they might encounter.

To ensure the cooperation of potential respondents, the persons gathering information must take the time to explain clearly the need for the information they are gathering. More important, they must be able to convince the respondents of how such information will ultimately benefit the community.

The persons collecting information should be instructed that, in addition to language difficulties, many of the potential respondents may not have had much, if any, experience filling out questionnaires; consequently, data collectors should be prepared to read the questions to the respondents in the respondents' preferred language. This will enable the persons collecting the information to explain any questions that are unclear and will thus ensure the validity and reliability of the information that is obtained.

Telephone Interview

Although gathering information via the telephone may be an expedient method with respect to cost and time, it presents challenges to the evaluator similar to those inherent in the personal interview method. If there is distrust and fear of providing information in a personal interview, these feelings will quite likely be intensified when respondents are asked to provide such information on the telephone. Without some form of personal contact and preparation regarding the purpose for which the information is being gathered, potential respondents may be reluctant to cooperate; or, if they do cooperate, they may not provide the most accurate information but may instead provide information that may be less revealing or more socially acceptable. Furthermore, it is quite likely that the Hispanic individuals targeted for preventive programs may also be those who are unemployed, who cannot afford a personal telephone, or who lead a transient life; thus, it is highly probable that gathering information via the telephone from many such individuals may be next to impossible. If, for logistical reasons (e.g., need to cover a large geographical region in a short amount of time), telephone interviews appear to be the most expedient method, there are certain steps evaluators can take to overcome the challenges associated with them. Most of these steps are quite similar to those suggested for the personal interview, and so they will not be reiterated here.

Mail Surveys

From a cost-effective perspective, there is no question that mail surveys facilitate and expedite information gathering. However, the low response rate often associated with mail surveys tends to dissuade many evaluators from using this method. Still, if resources require that mail surveys be used, it is important to note that this method is also plagued with the same challenges inherent in both personal and telephone interviews. In particular, as with the telephone interviews, the fact that many Hispanic subgroups who could benefit from preventive programs may lead a transient existence (e.g., migrant farm workers) makes the mail survey an unreliable method for gathering information. Therefore, the suggestions offered for the two interviewing methods are also appropriate for mail surveys. For instance, evaluators should make sure that appropriate Hispanic community leaders alert the targeted community to the forthcoming survey. In addition, the signature of such leaders should appear on the cover/explanatory letter that accompanies the survey. Finally, because evaluators may not know the preferred language of the potential respondents, it is essential that both Spanish and English versions be used.

Phase II: Taking Action

Phase II of the comprehensive evaluation model comprises the following steps that provide the basis for the actions inherent in both the program and evaluation process:

- Formulating program goals and objectives.
- Identifying program strategies and activities.
- Designing the program process and outcome evaluation measures.

Again, it should be noted that, although these steps are presented sequentially, the actions contained in each usually overlap or occur simultaneously.

Formulating Program Goals and Objectives

As with the other programmatic and evaluation efforts, the formulation of goals and objectives should be a joint activity undertaken by the evaluator, the program director, and the program staff. Whenever possible, input should also be sought from the established community advisory board to help ensure the appropriateness of the goals and objectives vis-à-vis the targeted community as well as to increase the community's receptivity to these goals.

In line with a comprehensive model of evaluation, goals and objectives should be developed for both program process and outcome evaluation efforts. For the purpose of differentiation, process-relevant objectives could help specify what resources will be allocated to whom so that the specified preventive services are delivered to the target population; a process objective might, for example, specify the number of times a stress management program might be offered for recent immigrants from war-torn countries (e.g., El Salvador or Guatemala). Outcome-relevant objectives, on the other hand, could focus on answering questions about the expected effects of the prevention services on the target population; for instance, is an "in-house" or a "field" intervention more effective in curtailing the use of inhalants by Hispanic gang members? The outcome-relevant objectives should also provide the key for selecting the measures with which to assess program effectiveness. As for the actual selection of specific process- and outcome-relevant goals and objectives, many suggestions contained in the section on the development or identification of needs assessment instruments are quite applicable and so will not be reiterated here.

Identifying Program Strategies and Activities

Although identifying or developing such strategies and activities should be the major responsibility of the program director and staff, evaluators working within a comprehensive model can play very important ongoing roles in this process. For instance, if they have a strong knowledge base regarding Hispanics, the evaluators can work from a consultative perspective. In addition, through ongoing involvement in the process, they can collect vital information that will help them in their process evaluation efforts. Finally, their involvement can expedite the identification or development of the outcome-measurement strategies and instruments.

For the evaluator and program staff who do not have a solid understanding of the Hispanic populace and all its complexities and who are not strongly familiar with the counseling, mental health, or social service research relative to this populace, identifying or developing effective intervention strategies and activities can be a formidable task. Fortunately, although information specifically tailored to preventive programs is still very sparse, counseling, mental health, and social service information and research regarding Hispanics have greatly increased during the last 10 years. Concomitantly, the quality and usefulness of this information have also greatly improved during this time (see Ponterotto and Casas 1991).

In a previous section of this chapter, psychosocial research findings were highlighted to demonstrate how such information can be used for programmatic and evaluation purposes. At this point, selected sociocultural information presented by Padilla and Salgado de Snyder (this volume) is highlighted with the same purpose in mind:

- The important role given to the family in the traditional Hispanic culture should be a factor to be reckoned with in efforts against the spread of AIDS. The impact of AIDS on the family, and especially on the children, could be a key factor in motivating the behavioral change of high-risk individuals. Having a strong family orientation, Hispanics may also be more highly motivated to talk to other family members about prevention (Marín, in press). Working from this perspective, prevention programs might give serious consideration to providing relevant information in a culturally sensitive manner to authoritative figures in the family (i.e., parents, older brothers and sisters), who in turn would be asked to share the information with their children or younger siblings.
- Given the high value that many traditional Hispanic women place on children and fertility (see Ortiz and Casas 1990), a major thrust for prevention programs could be the negative consequences of AOD misuse and abuse on women who want to have healthy children.
- Another reason for family-oriented prevention interventions is that less acculturated Hispanics may avoid sharing their problems outside the family circle (Marín, in press). Furthermore, there is some evidence that programs that involve the family of the youth at risk can have more successful outcomes (Santisteban and Szapocznik 1982).
- Given the finding that a significant number of Hispanic drug users maintain close contact with their families (Jiménez 1980) and that Hispanics report a willingness to intervene with family members at risk, a good argument exists for using family members in both preventive and treatment-oriented programs. To facilitate such efforts, Sorensen and Bernal (1987) have developed a detailed guide for family members who wish to help AOD-abusing relatives as well as to understand why these relatives abuse alcohol and other drugs.

- It is quite likely that people who are less acculturated may have significantly less accurate information about AOD misuse/abuse and related problems than those who are more acculturated. Should this be the case, prevention efforts may need to include different strategies and themes to reach individuals at different levels of acculturation.
- In providing educational programs, all relevant personnel must be aware that, for more traditional Hispanics, the concept of *simpatía* (a central cultural value and social script that mandates politeness and respect) may require Hispanic listeners to appear to agree with a message even though they do not understand it or have no intention of following the advice (Marín, in press). This makes it crucial that preventive program personnel ask questions to ensure that AOD-related information has been correctly understood.
- Given the prevalence among more traditional Hispanics of *personalismo* (a preference by Hispanics for relationships with others in their social group), it might be advisable to have persons who are well known and respected in the community provide the intervention activities and to do so from the low-key perspective of plática (friendly conversation) (Marín, Marín, & Juarez, 1988).
- For highly at-risk subgroups (e.g., injected drug users) or for those who might disdain using traditional social service settings (e.g., street gangs), the preventive activities, especially those providing information, may need to be carried out in areas where persons from such subgroups are most likely to be found (e.g., public parks, shooting galleries, halfway houses, and homeless shelters).
- Drawing from the AIDS-related work of Marín and Marín (1989), programs that seek to develop educational campaigns concerning the harmfulness of AOD abuse among Hispanics should consider a number of issues if they are to be effective. First, Hispanics have group-specific patterns of media use (Alcalay et al. 1987–88; Shoemaker et al. 1985) that favor the reliance on certain information channels over others; furthermore, more traditional Hispanics may per-

ceive certain sources of information as more credible than others because of cultural norms that demand special deference and respect toward individuals in roles of authority (Hofstede 1980). More specifically, in a study conducted by Marín and Marín (1989) on the credibility of varied sources and channels for providing AIDS information to Hispanics, respondents perceived a hotline and printed information (e.g., books, pamphlets) to be highly believable channels of AIDS information. Individuals in closer contact with the disease (e.g., a physician, a counselor, a person with AIDS) were overwhelmingly perceived to be the most credible sources of information. If these findings can be generalized to AOD prevention efforts, the high credibility assigned to hotlines and to printed materials strongly suggests that these channels of information be used in programs to prevent AOD problems.

♥ To ensure positive outcomes from the use of these channels culturally appropriate messages and materials must be developed. To this end, according to Marín and colleagues (August 1988), a careful developmental stage that includes identification of culture-specific attitudes, values, and expectancies will need to be considered when developing the messages. In addition, a multifaceted pretesting phase should be carried out. Finally, experiences with other areas of health promotion among Hispanics (e.g., cigarette smoking) can serve as models for this process (Marín et al., in press).

♥ To reach a maximum number of Hispanics, preventive programs must use multiple English- and Spanish-speaking communication channels (radio, television, *novelas*, newspapers, etc.).

♥ Taking *personalismo* into consideration, community outreach workers associated with the prevention program should consider personally providing information and motivational messages directly to the community through meetings of fraternal organizations, community groups, and churches (Marín, in press). To this end, programs might consider using individuals who have had drug-related experiences as role models to discuss the negative effects of AOD abuse, explain how they were able to change their habits, and describe the benefits they are experiencing as a result of this change. If such testimonials are used, according to Marín (in press), it is vital that they be carefully developed and pretested so that they are clear and motivating and do not conflict with other messages in the prevention campaign.

Designing the Program Process and Outcome Evaluation Measures

As with the other steps, this one should be undertaken as a collaborative effort with program personnel. The procedure and justification for the program process evaluation were addressed in some detail in the first part of this chapter and will not be reiterated now. Program process evaluation is an ongoing process that noncritically measures the programmatic efforts to attain the short- and long-term objectives inherent in the program. In a nutshell, it provides feedback throughout the duration of the program that can be used to increase the probability of attaining the desired program goals and objectives.

Given the nature and purpose of this type of evaluation, the measures and procedures that can be used are nonexhaustive, with the only limitation being a lack of creativity on the part of the evaluators. For instance, if an integral part of the program is sponsoring community planning meetings throughout the program's duration, the type of information that might be collected relative to these meetings could consist of a calendar of all meetings that are scheduled and subsequently held; a roster of the topics scheduled to be addressed; a head count of the total number of participants; a breakdown of the participants according to what group or agency, if any, they are representing; the actual topics and concerns raised by the participants; and the level of satisfaction with the overall thrust of the meeting as it relates to ongoing prevention activities. The program director and staff should keep track on a weekly basis of all the activities in which they engage and should log these activities under the headings of the specific objectives of the program.

To gauge the ongoing effectiveness of educational programs (i.e., meetings) earmarked for a specific at-risk group (e.g., adolescents who have been cited for driving under the influence) and to make any necessary adjustments to these meetings, it might be prudent to collect information on how the meetings are advertised; what efforts are taken to recruit potential participants; where and when the meetings are being held; who is running the meetings; how many returning persons attend each meeting; how many new persons attend; what information is covered in the meetings; and how the meetings affect the drinking attitudes and behaviors of those who consistently attend them as scheduled.

As mentioned in the first part of this chapter, outcome evaluation is the type of evaluation with which social scientists, government funding agencies, and community program developers are most familiar. Outcome evaluation assesses the attainment of program objectives related to short- and long-term changes in participants' behavior, attitudes, knowledge, or level of problems or dysfunctions; it also assesses the longer-term generalized results of program operations.

The types and numbers of outcome evaluation measures that are actually used depend on the information desired by the evaluators and the program personnel and required by the funding agencies. Quite likely, the program personnel will want the type of information they can use to improve future preventive program efforts; the funding agency, on the other hand, will want information on the successful outcomes of the program and, in particular, on its cost-effectiveness.

As previously recommended in this chapter, designing or identifying appropriate outcome evaluation measures and procedures can be greatly facilitated if the evaluators work from a consultative perspective with the program staff in setting program goals and objectives and in developing or identifying the activities that will be used to attain them. Like the needs assessment data, the desired outcome data can be obtained directly with surveys and questionnaires from the targeted Hispanic population, program personnel, and other relevant agency personnel, or it can be obtained, as previously described in the needs assessment section, with nonobtrusive methods (e.g., institutional archival data).

If the preferred method is the direct one, the main task of the evaluators at this point is to develop or identify standardized measures and procedures that are statistically valid and reliable as well as socioculturally and educationally appropriate for use with a targeted Hispanic subgroup. The recommendations for developing or identifying such instruments are similar to those provided in the section on developing the needs assessment instruments and so will not be repeated here. As in the section on needs assessment, the reader is referred to the appendix, in which selected outcome research measures are identified.

Phase III: Evaluating Action

Phase III of this comprehensive evaluation model comprises the following steps:

- Collecting and analyzing all program/process and outcome evaluation data.
- Reporting and disseminating the process and outcome results.

Unlike the steps in the other phases of the model, these steps must follow each other sequentially. The data must be collected and analyzed before any results can be reported. However, given the nature and purpose for conducting program/process evaluation, the collection analysis and subsequent internal reporting of process results will be ongoing efforts throughout the life of the program.

Collecting and Analyzing All Program Process and Outcome Evaluation Data

Because the directions, recommendations, and cautions that were presented regarding the assessment of existing needs and risks are quite relevant to the collection of all evaluation data, they will not be repeated now. Suffice it to say that establishing a strong cooperative and collaborative working relationship with the program personnel, the community, and targeted program participants will greatly expedite the data collection.

After all program process and outcome research evaluation data are collected, the evaluators must analyze the data and interpret the findings. The actual mechanisms for analyzing the data are quite familiar to evaluators and social scientists and so will not be addressed here. However, to illustrate the fact that evaluators must be sensitive to some issues that are unique to the analysis of data from Hispanics, a few comments regarding the analysis of such data are warranted. For instance, as noted earlier, Hispanic subgroups can differ significantly across social and economic variables; consequently, evaluators must carefully assess when, for the sake of analyses, it might or might not be appropriate to collapse the data collected across such subgroups. From another perspective, evaluators should take care not to merge or combine data collected using both Spanish and English surveys unless the content equivalency of both surveys has been statistically validated.

To ensure the accurate interpretation of the outcome research findings, evaluators and program personnel should carefully examine these findings taking into account all the process data collected throughout the duration of the program. The reason for this is that the process data may help evaluators and program personnel to understand why certain activities and strategies may have been more effective than others. In addition, evaluators and program personnel should meet with the community advisory board to tap into its expertise regarding any and all sociocultural variables that need to be considered in viewing the outcome results realistically. For instance, such input might help generate various plausible reasons for why an educational group intervention earmarked for Hispanic women did not attain desired outcomes. Such reasons might be that the information media used to advertise the group did not reach the appropriate community agencies; that the designated leaders of the group were not acceptable to the targeted population; or that the group meetings were held at the time when the most popular *novela* was being aired on television. Obviously, such input would greatly help to generate the type of information that could be used to increase the likelihood of success for future similar preventive program ventures.

Reporting and Disseminating the Program Process and Outcome Evaluation Results

The final step in this comprehensive model focuses on reporting and disseminating the process and outcome evaluation results. To most evaluators, this is a fairly straightforward process that involves detailing the results in the end-of-year or end-of-program report, disseminating the report to the funding agency, and disseminating possibly summarized versions of the report to those agencies and institutions that were in some way involved with the program. If the evaluators believe the results merit further visibility, they may issue selected results in the popular news media or write them up for publication in a professional journal; in so doing, they would increase their own visibility and professional reputation as evaluators.

Although this process might be quite acceptable from a professional perspective, it falls short from an ethical and responsible perspective relative to those Hispanic communities that are likely to be targeted for preventive programs. Given the general characteristics of the Hispanic populace, it is highly probable that the targeted communities may be of low income, have a low level of education, and suffer from a variety of social problems. If so, it behooves both evaluators and program personnel to take an active part to ensure that positive results reach as many members of the community as possible, especially those in leadership positions. To this end, the evaluators should make use of the medium that is most effective in delivering information to the community; in most cases, this would obviously *not* be a professional journal. Providing such information to people in the community could help raise the hope and expectation that AOD problems are not insurmountable, that there are practical things that can be done, and that they as a community can do them—in a nutshell, the belief that *¡SI SE PUEDE!* (loosely translated, IT CAN BE DONE!).

Along this same line, evaluators should be willing to provide to any and all educational and social agencies that serve the community detailed information on the activities and strategies that led to the positive outcomes. This information would enable such agencies to replicate the successful activities and strategies and, in so doing, maximize the benefits that can accrue to the community.

Finally, to maximize the benefits that accrue from a successful prevention program, the evaluators must abandon the guise of scholarly detachment and objectivity and use their positive evaluation results to influence public policy in an active way. To this end, selected results should be personally delivered or sent by both evaluators and Hispanic community leaders to specific city, county, State, and Federal officers who, through legislation or budgeting, can influence the future direction of preventive programs earmarked for Hispanics.

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Appendix

The following scales, questionnaires, surveys, and inventories are examples of instruments that have been directly developed and/or statistically validated for use with different Hispanic subgroups.

Acculturation Rating Scale for Mexican Americans (ARSMA): developed by Cuellar, Harris, and Jasso (1980) to provide a measure of acculturation for both normal and clinical Mexican-American populations.

Center for Epidemiological Studies Depression Scale (CES-D): developed to measure depression (Radloff, 1977). Its applicability and validity relative to use with Hispanics has been examined (Golding & Aneshensel, 1989).

Feminine Interest Questionnaire (FIQ): developed by Miller (1977) to measure attitudes toward modern and traditional sex roles. Validated for use with Hispanic women by Ortiz and Casas (1990).

Hispanic Stress Inventory: developed by Cervantes, Padilla, and Salgado de Snyder (1990) to assess psychological stress in the lives of immigrants from Latin America. Comes in two forms: one for immigrants from Latin America and the second for later-generation Mexican Americans. Can be obtained from A.M. Padilla.

Harrington-O'Shea System of Career Decision Making: Spanish version developed by Harrington and O'Shea (1980) for use in career decisionmaking counseling. Validated for use with Mexican Americans, Puerto Ricans, Cubans, and South Americans.

How I Feel About Myself: developed by Furlong and Casas (Casas et al., 1988) to measure the school self-concept of Mexican-American adolescents.

Sexual Attitude Questionnaire (SAQ): developed by Miller (1977) to measure the degree to which women value exerting high inhibition, control, and regulation over sex, and engaging in sex solely for the purpose of procreation and/or pleasing their husbands. Validated for use with Hispanic women by Ortiz and Casas (1990).

TEMAS (Tel-Me-a-Story): developed by Constantino, Malgady, and Rogler (1988) as a thematic apperception test developed specifically for African-American and Hispanic children but useful with all children. Distributed by Western Psychological Services.

Value Orientation Scale (VOS): developed by Szapocznik, Scopetta, Arnalde, and Kurtines (1978) as part of a process to establish a therapeutic model appropriate to the cultural characteristics of Cuban Americans.

What Is Happening in My Life: developed by Furlong and Casas (Casas et al. 1988) to measure the types of stressors that might affect Mexican-American adolescents.

Woodcock-Johnson Psycho-Educational Battery-Revised (WJ-R): developed by Woodcock and Johnson (McGrew, Werder, & Woodcock, 1991) and validated for use with Hispanic persons (Spanish version available).

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5

Hispanics: What the Culturally Informed Evaluator Needs To Know

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Abstract

Alcohol and other drug (AOD) abuse is a significant social problem among Hispanics. This chapter presents information that will give program evaluators a better understanding of the sociocultural diversity found among the various Hispanic groups in the United States. Factors that contribute to successful social and psychological integration of Hispanics are discussed because of their relevance to possible AOD use by this population and because such information is critical if prevention and intervention programs are to succeed. The chapter focuses particular attention on women, immigrants, and youth, groups that are particularly prone to be at high risk for psychological distress. The chapter takes the position that successful evaluation of social programs necessitates knowledge of the Hispanic community and of the conditions that place an individual at risk for misusing or abusing alcohol and other drugs.

Introduction

The importance of cultural considerations in the evaluation of alcohol and other drug (AOD) problem prevention programs for Hispanics cannot be overemphasized. It is important to recognize that cultural considerations have not been given much weight in evaluation research to date, and so important outcome measures may have been missed by evaluators not familiar with cultural nuances. We contend that there are many reasons why evaluators need to be knowledgeable about the Hispanic population, its history and culture, and the ways in which it uses or underuses social service programs.

It is our intent here to provide a broad overview of the Hispanic population in the United States. As we begin this chapter, it is important for the reader to understand two basic premises. The first is that the Hispanic population does not represent a unitary ethnic group; rather, there are many Hispanic subgroups that vary by Latin American national origin, racial stock, generational status in the United States, and socioeconomic level. In other words, the population is marked by considerable heterogeneity. The second premise is that, although there are communalities that have been well summarized in the literature describing the Hispanic culture (e.g., the Spanish language, Catholicism, family orientation, and gender roles), many of these cultural orientations have been undergoing modification in recent years. For instance, we know that gender roles have become more flexible in the past two decades in Latin America as a consequence of the spreading feminist movement worldwide. Accordingly, this chapter will present a view of Hispanics that takes these sociocultural changes into account. We maintain that, in working with Hispanics, the culturally competent evaluator must appreciate intragroup variability as much as intergroup diversity.

We also believe that it is difficult in a few pages to orient an "outsider" to a cultural group about which he or she knows relatively little. However, we think it is possible for the outsider to begin to appreciate the "insider's" perspective. If this process takes place, the evaluator will start to ask research and evaluation questions that take into account the insider's point of view in a much more relevant way than has been previously true in evaluation research involving Hispanics.

A Profile of Hispanics

We believe that terminology is critical to understand intragroup heterogeneity. Therefore, we begin by clarifying the term *Hispanic* because it is frequently misunderstood. Hispanic is a term that made its first appearance in the late 1970s and then was used by the U.S. Bureau of the Census in 1980 to designate those individuals who reside in the United States and whose cultural origins are in Mexico, Puerto Rico, Cuba, Central America, and other Latin American countries. In some contexts, Hispanic may also include Spaniards and Brazilians. However, because the term was not used as an ethnic label before its introduction in the late 1970s, it is not accepted by many members of the group. Thus, it is not uncommon to find reference to terms such as *Latino* or *la raza* (literally, "the race") as the preferred ethnic labels in many communities. Similarly, there is diversity of opinion about which label is most appropriate (Lampe 1984) within each subgroup. For example, among Hispanics with ties to Mexico, one is likely to find reference to *Mexicano, Mexican American, Chicano,* and even *Spanish American* as terms of self-identification used by various segments of the population. So problematic is the term *Hispanic* and the heterogeneity among the population that Klor de Alva (1988) felt compelled to state

> *The mass media, advertising firms, government agencies, and the non-Hispanic population attempt to simplify their response to the burgeoning Spanish-speaking population by obscuring their substantial differences through collective labels (like "Hispanic") and stereotypical assumptions concerning their supposed common cultures and socioeconomic conditions. Different Hispanic groups, generally concentrated in different regions of the country, have little knowledge of each other and are often as surprised as non-Hispanics to discover the cultural gulfs that separate them (p. 107).*

Despite the problems of labeling and the heterogeneity of the population, we use Hispanic in this chapter because of its wide acceptance by service providers.

With issues of terminology out of the way, we can now turn to census information, which indicates that there are now more than 20 million Hispanics in the United States (U.S. Bureau of the Census 1990). The majority (63 percent) are people of Mexican origin who reside primarily in the Southwest and West, followed by mainland Puerto Ricans (12 percent) located principally in the Northeast, and Cubans (5 percent) located primarily in the Southeast. In the past 10 years, we have also witnessed a large immigration of Central Americans to the United States. These individuals have come primarily from the civil war-plagued countries of Guatemala, El Salvador, and Nicaragua. Unfortunately, it is not possible to know with certainty how many Central Americans there are in this country because the Census Bureau combines Central Americans with South Americans. We do know from census data that there are more than 2.5 million Central and South Americans in the United States and that they constitute approximately 13 percent of the total Hispanic population. However, unofficial estimates place the number of Central Americans at more than 2 million individuals. Dominicans who reside principally in the Northeastern Atlantic States are another group beginning to gain prominence. Finally, current demographic projections indicate that Hispanics will be the largest minority group in the United States sometime between the years 2000 and 2010.

Contrary to the public perception that Hispanics are agricultural workers, approximately 90 percent of Hispanics live in large urban centers. However, the great majority of Hispanics hold unskilled or semiskilled occupations. Compared with the total U.S. non-Hispanic White population, Mexican Americans are young (median age, 23.6 years versus 33.2 years), generally less well off financially (median family income, $21,325 versus $33,142), and undereducated (median number of school years completed for individuals aged 25 and over, 10.8 versus 12.7), and they suffer from a higher rate of unemployment (8.5 percent versus 5.2 percent). Puerto Ricans are also young (median age, 26.8 years) and quite poor (median family income, $18,932). About 30 percent of Puerto Rican families live below the poverty level, are lower in educational attainment (median number of school years completed, 12.0), and experience high unemployment (9.1 percent). Finally, about 40 percent of all Puerto Rican families are headed by single females. In contrast to Mexican Americans and Puerto Ricans, Cubans are, on average, older (median age, 41.4 years). However, like the other two major Hispanic subgroups, Cubans are also relatively less prosperous (median family income, $26,858) but have a lower rate of unemployment than the other two groups (6.1 percent). The median number of school years completed for all Cubans aged 25 and over is 12.4 years. Census information on Central and South Americans shows that this combined group has a median age of 28.4 years, a median family income of $24,322, and an unemployment rate of 6.2 percent. It is probable that if a profile were constructed for only Central Americans, their socioeconomic status would be lower than it is when combined with South Americans.

Overall, the social condition of Hispanics, along with their continued immigration from Latin America, will unquestionably continue to affect their social, economic, and political life in this country as well as the entire fabric of the United States (Hayes-Bautista et al. 1988). All social indexes point to the fact that Hispanics, especially youths, constitute a population that is at high risk for experiencing a greater incidence of physical and psychological problems. The extent of this risk is only beginning to be understood by social service providers, educators, and social policy researchers.

To understand the risk factors for any specific Hispanic subpopulation and properly gauge the extent of the problem, we must take into account several demographic facts. For example, to assess the extent of alcohol and other drug use among Hispanics, we need to ask ourselves what baseline data we should use to determine whether AOD use rates are high. If we are considering Mexican Americans, is baseline epidemiological information based on the general U.S. population appropriate for this group? Should alcohol consumption rates of first-generation and possibly unacculturated Mexican Americans be compared with baseline data obtained in Mexico? These questions, along with similar concerns, need to be considered when an AOD problem prevention program is being planned and certainly when such a program is being evaluated. Before outcome measures can be planned to assess program effectiveness, the evaluator must consider whether the expected outcomes are realistic, given the sociocultural context of the Hispanic group being studied. Further, questions of control groups must be addressed in this context; that is, who constitutes the appropriate baseline group when evaluating inhalant use rates among Mexican-American adolescents?

We now turn our attention to a brief historical overview of each major Hispanic subgroup. It is important for the culturally competent evaluator to know something about the history of the groups with which they are working, given that each group has a distinct history that shapes the relationship it has within the United States and with non-Hispanics.

Historical Background of Major Hispanic Groups

Mexican Americans

The American Southwest and Far West were controlled by Mexico until 1848. Spanish was the primary language, and Spanish-Indian culture flourished.

During the first half of the 19th century, the United States instituted its policy of Manifest Destiny, and this rationale for expansion into the Southwest gained momentum when the Santa Fe Trail was expanded through the territory in 1820. The U.S. drive for land led to war with Mexico in 1846 (Merk 1966). The war came to an end in 1848, when Mexico surrendered its northern territory, including the present-day States of New Mexico, Colorado, Utah, Nevada, Arizona, and California. Mexican citizens in the territory were allowed to move south across the new border or to remain and became citizens of the United States.

The rights of those Mexicans who elected to remain in the United States were protected under the Treaty of Guadalupe Hidalgo (McWilliams 1968).

As McWilliams points out, however, no provisions were made in the treaty to integrate the "native" people into the general mainstream of society. The Mexicans were granted cultural autonomy but were denied access to mainstream institutions. They lost their land through a series of land schemes and were forced into agricultural labor. In the process, they were also denied equal educational opportunity and were discriminated against in jobs and housing (McWilliams 1968). Thus, these people were forced into an inferior social position.

These Mexican Americans remained isolated until the period 1910 to 1920, when they were joined by Mexican emigrants fleeing the revolution in Mexico. These newcomers established colonies primarily in California and Texas. Mexican Americans, although paid poorly, were able to find employment except during times of economic hardship; in fact, during the Great Depression, approximately 400,000 U.S. citizens of Mexican origin were deported to Mexico by officials who justified their action by indicating that they were not obligated to assist "foreigners."

Beginning with World War II, the United States found itself short of labor, and it entered into an agreement with Mexico to obtain a steady supply of cheap laborers. In 1944 alone, a total of 110,000 Mexicans entered the country to work on railroads and in agriculture and manufacturing. After the war, the United States and Mexico continued the arrangement through an agreement known as the Bracero Program. *Braceros* were contracted in Mexico as seasonal laborers to work in the agricultural fields of California, Washington, Texas, and the Midwest. Many of these workers eventually established roots in this country and remained.

Although the Bracero Program ended in the late sixties, Mexicans have continued to immigrate to the United States. Like so many other immigrant groups before them, they come in the hope of bettering their economic situation. Today, significant populations of Mexican Americans live in California, Texas, Arizona, New Mexico, and Illinois. It is not unusual to find individuals who, because of historical events, can trace their ancestry in this country back for many generations and who no longer have a direct link to Mexico. At the same time, older-generation Mexican Americans mix almost daily with Mexican immigrants. Despite the differences brought about by acculturation and adaptation to the United States, individuals of Mexican origin—regardless of their generation—share many communalities that bind them together as an identifiable ethnic community.

Puerto Ricans

Current-day Puerto Rico was colonized by Spain in the 16th century. At that time the island was inhabited by Tainos Indians. However, the natives were outnumbered and largely eliminated by the Spaniards (Fellows 1973). Gradually, Africans were transported against their will to work the land. These slaves were not segregated by the Spaniards to the same extent that they were by the British, and eventually they intermarried with the White and indigenous people of the island. Today, most Puerto Ricans claim both African-American and White origin (Longres 1974).

In 1898, at the end of the Spanish-American War, Spain ceded control of Puerto Rico to the United States. For a time the island was assigned an ambiguous status that did not allow statehood because its citizens were considered "racially inferior" (Longres 1974). With the Jones Act of 1917, however, Puerto Rico became a commonwealth territory of the United States. With commonwealth status, Puerto Ricans were granted U.S. citizenship and could move freely from the island to the continent without an immigration check. Puerto Rico, with its 3 million inhabitants, continues to be a Commonwealth of the United States.

In around 1900, Puerto Ricans began to move to New York City in search of employment. Later, they continued to settle in New York because of the ethnic social network already established there (Burma 1954). Puerto Ricans who migrate to the United States are of diverse socioeconomic backgrounds. In the past, they included sugar cane workers, coffee growers, and middle-class urban dwellers; today, they are just as likely to be members of all social classes. Second- and third-generation mainland Puerto Ricans can be found in all major northeastern urban areas. Like Mexican Americans, these later-generation Puerto Ricans share some cultural orientations with their island relatives, but at the same time they have also developed a distinct Puerto Rican mainland culture (Padilla 1987; Rodriguez 1990).

Cubans

Like Puerto Rico, Cuba was colonized by Spain. Slaves from Africa were brought into the country in the 1700s and mixing of slaves, Indians, and Spaniards began shortly thereafter. As a consequence of intermarriage, Cubans now contain the full range of genetic makeup from White to African American.

With help from the United States, Cuba gained its independence from Spain in 1889 and thereafter developed an agricultural and tourist economy that became highly dependent on American dollars. A small entrepreneurial class controlled most of the wealth.

In 1959 the Cuban revolution, led by Fidel Castro, received the support of the working class, who had become disenchanted with the government. Eventually, Castro ousted President Fulgencio Batista and assumed the presidency. The new Communist-oriented regime soon forced the exodus of large numbers of upper-class Cubans.

Cuban immigration to the United States can be divided into several phases. The first period was shortly before and after January 1959, when Castro seized power. About 3,000 members of the elite upper class entered the United States, bringing with them considerable wealth. The second phase occurred during 1959 and 1960, when many upper-class owners of farms, ranches, and businesses decided to leave Cuba. The third phase took place at the end of 1960, when other middle-class Cubans, including professionals, managers, technicians, and heads of companies, immigrated to the United States as their properties and wealth were seized. The fourth phase began after the Bay of Pigs fiasco of July 1961. Those Cubans who wanted to immigrate to the

United States were allowed to take with them only necessities, which translated into a few clothes and no more than $5 cash. This fourth contingent of upper-middle and middle-class Cubans continued to leave, as did lower-class office workers and skilled and semiskilled workers. The fifth phase occurred between October 1962 and December of 1965, when about 9,500 Cubans escaped in small fishing boats after Castro blocked refugee air flights. The sixth phase of migration began in December 1965, when Castro and President Lyndon Johnson reinstated the refugee flights. When political channels were reopened, about 200 immigrants arrived in Florida every day for months. In addition, some 20,000 Cubans residing in Spain entered the United States when they were able to obtain visas. Throughout this period, the U.S. policy toward Cubans was to grant them refugee status, which entitled them to resettle in the country legally.

The last wave of Cuban immigrants to the United States came in 1980. Approximately 125,000 Cubans, in a mass exodus from the Cuban port city of Mariel, arrived aboard private fishing vessels that had been launched from South Florida. These *marielitos*, as they came to be called, were overwhelmingly working-class African-American Cubans; 70.9 percent were blue-collar workers, and, contrary to popular belief, no more than 20 percent of them were prison inmates or mental patients. The Mariel exodus changed the image of Cubans as a professional and business-oriented middle class and has been the cause of much friction within the community itself (Acosta-Belen 1988).

Central Americans

Central Americans represent the most recent newcomers from Latin America to the United States. Many Central American immigrants relocate in the United States for a combination of reasons, including a desire to escape both the extreme economic hardship in their country and the political turmoil that threatens them. The majority of immigrants from Central America come from Guatemala, El Salvador, and Nicaragua, where the political strife has resulted in extreme violence, including kidnappings, disappearances, shootings, and torture. As a result, the incidence of posttraumatic stress disorder (PTSD) among Central Americans is quite high (e.g., see Cervantes et al. 1989).

Accurate data on the number of Central Americans living in the United States are not available. Unlike the Cubans after their exodus, few Central Americans are granted refugee status, and possibly the majority in the United States are here without legal documentation and are subject to deportation if apprehended. However, more than 500,000 Central Americans have been reported to reside in the Los Angeles metropolitan area alone (Central American Refugee Aid Fact Sheet 1988).

Other Hispanics

The Spaniards conquered various Indian groups, and contact between the Spaniards and the indigenous groups resulted in mestizo ethnicities and cultures throughout Latin America. Spain's domination continued through the 18th century. Beginning in the 19th century, however, many parts of Spain's New World empire began to revolt. Ultimately, South American countries won their independence. Since their beginning as independent nations, Chile, Argentina, Peru, and Colombia have shared many cultural origins and today face similar economic and social problems. Despite these and historical similarities, however, the countries have varied economic, political, and social systems.

There is a dearth of information about Hispanics who emigrate from South American countries to the United States. We know very little about their migration patterns, reasons for migration, and other migratory characteristics. Some leave their countries because of internal war or because their political views differ from those of the government; others migrate to further their education or to improve their economic situation.

Summary

We have provided a very brief historical sketch of the major Hispanic populations to show the heterogeneity that marks this ethnic group. Labeling Mexicans, Puerto Ricans, Cubans, and the diverse Central American groups as Hispanic serves the purpose of expediency in that it allows a large number of people to be categorized under a single term. However, in the process of finding a common label, the diversity of the different groups is lost. As noted previously, each group has a distinct history in the United States, which has shaped its relationship with the dominant society. At the same time, each group has its own history that defines its national identity and social structure. Thus, even though there are many factors that tie Hispanics together as an ethnic group within the United States, such as the Spanish language, reliance on the family as the significant social structure, and the Catholic church, there are also many differences among the groups.

It is important for the culturally competent evaluator to know about the sociohistorical context of the Hispanic clients served by any program being evaluated. We know there are important intragroup differences in generation and acculturation level as well as in personal characteristics that need to be considered when establishing programs for Hispanics. For example, later-generation adolescents have been shown to have lower self-esteem scores than immigrant adolescents, and immigrant women show much higher rates of abstention from alcohol and other drugs than do their later-generation counterparts.

Similarly, although two immigrants, one from Mexico and the other from El Salvador, may both speak Spanish and may be experiencing many of the same difficulties in adjusting to life in the United States, there are very important intergroup differences that need to be understood in evaluating the services being provided to each. The Salvadorean is very likely to have had direct experience with war-related incidents and, as a result, may suffer PTSD. A Salvadorean may have emigrated to escape the civil war and to protect his or her preadolescent sons from induction into the military. The Mexican, on the other hand, might have as his or her principal motive for emigrating the attainment of secure employment. With employment, this person may then be able to send money to Mexico to assist other family members who are struggling economically.

To the uninitiated evaluator, the two immigrants may not differ. However, to the evaluator who recognizes the importance of the sociocultural context, it should be immediately obvious that different predisposing factors need to be considered when planning outcome measures. Similarly, the adequacy of the psychological instruments used also differ among the Hispanic subgroups. An instrument that has been adapted for use with one subgroup may not work with another.

Finally, the culturally sensitive evaluator also needs to be familiar with the current community issues that affect how a community is functioning. These issues often involve, for example, political, educational, or social service concerns that need to be incorporated into the evaluation of an AOD use treatment program. Especially important for the evaluator is information about how the community responds politically to issues that threaten its survival as well as knowledge of community resources and leadership style. In some instances, politics and community resources have historical origins that are critical to the evaluator in understanding how Hispanics use social services. Knowledge of the community, both historically and contemporaneously, will inform the evaluator as to the proper planning of evaluation strategies that are useful and nonobtrusive to the community.

Changing Perspectives of Hispanics

With some of the sociocultural considerations behind us, we can now discuss three themes that have emerged in recent years as being particularly important in Hispanic research. We introduce these themes because we believe they are important for evaluators to know about when working with Hispanics. These themes are Hispanic women, immigrants, and youth.

Hispanic Women

Hispanic women have long been misunderstood in the social and psychological literature. They have been portrayed as passive and submissive to the male. However, this traditional stereotype of the female role in Hispanic culture has been extensively called into question during the past decade. In fact, studies refute the idea of male dominance and female submissiveness, thereby challenging the rigid gender roles attributed to Hispanic men and women (Cromwell and Ruiz 1979; Zamudio 1987).

Major changes have taken place in Hispanic marriages and family relationships during the last decade. Most of these changes directly affect the role of women and may be explained by any or all of the following factors: (1) the acculturation process, resulting from increased exposure to the host culture, in which American women have considerably more freedom than Latin American women; (2) an increase in the educational level of women, resulting in more exposure to changing conceptions of women worldwide; and (3) the increased participation of women in the labor force (Vazquez-Nuttall et al. 1987). Despite the cultural and social advancements made by Hispanic women in the past decade, however, these women remain behind when one considers the social gains made by non-Hispanic women. Unfortunately, because of the social, economic, and cultural conditions defining their lives, many Hispanic women remain in a vulnerable position that places them at risk for developing social and psychological problems, including depression and AOD use and abuse (Golding and Karno 1988; Salgado de Snyder 1986).

The demographic profile of Hispanic women differs, depending on which Hispanic subgroup we are addressing. According to the U.S. Bureau of the Census in 1985, the educational attainment of Hispanic women aged 25 or older was lower than that of non-Hispanic women (11.5 versus 12.7 years of education). Mexican-origin women had the lowest level of educational attainment (median was 10.2 years), followed by Puerto Rican women (11.2 years), Cuban women (12.0 years), and Central American women (12.4 years) (U.S. Bureau of the Census 1985*a*, *b*). Census data further indicate that like their non-Hispanic counterparts, nearly one in two Hispanic women were in the labor force (49.7 percent). Five years later, the bureau reported that labor force participation was higher among Cuban and Mexican American women (49 percent and 53 percent, respectively) than among Puerto Rican women (42 percent) (U.S. Bureau of the Census 1990).

Hispanic women have higher unemployment rates when compared with Anglo women. When employed, Hispanic women are generally found in low-status, low-paying jobs in agriculture, and as clerical workers, operatives, and service workers. In addition to earning low salaries if employed, Hispanic women overall are more likely to live below the poverty level. And because Hispanics generally have larger families, their mean per capita income is lower than that for non-Hispanic families ($4,981 versus $7,941).

It is important to mention also that the number of Hispanic single heads of household is increasing in the United States. This is a departure from the stereotype of the traditional Hispanic married woman who is completely devoted to her spouse and family. Unfortunately, little attention has been given to the many Hispanic women who do not conform to the traditional family model. For example, from all indications, the divorce rate among Hispanics is increasing; in 1985, one in seven Hispanic women over age 15 was separated or divorced (U.S. Bureau of the Census 1985*a*). Hispanic women are twice as likely as Anglo women to be heads of household (24 percent versus 12.8 percent). Furthermore, Hispanic families headed by a female are twice as likely to fall below the poverty level than non-Hispanic female-headed households (53.4 percent versus 27.1 percent) (U.S. Bureau of the Census 1985*b*).

Another important consideration is that the fertility rate is higher for Hispanic women than it is for non-Hispanics. Moreover, in 1984 it was estimated that about 25 percent of Hispanic births were to unmarried mothers, in contrast with only 11 percent of non-Hispanic births. And Hispanic women are more likely to begin childbearing earlier, generally in their teens, than their cohort of non-Hispanic women. It has been documented that teenage childbearing is linked to a variety of psychological as well as physiological problems for both the mother and the child (Russo 1985).

Although much research still needs to be carried out with women, there are some interesting data with respect to AOD use that bear mentioning here. According to the National Household Survey of Drug Abuse, the first major effort to understand the drinking patterns and practices of all U.S. Hispanics, there is a marked ethnic difference between Hispanic and Anglo American women in alcohol use rates. Anglo females were found to have considerably higher lifetime use rates than Hispanic females (83.3 percent versus 68.9 percent) (NIDA 1991). Although this survey did not take into account Hispanic subgroups or respondents' status as immigrants or later-generation Hispanics, a study by Caetano (1988) did consider these factors when analyzing for consumption rates. Caetano shows that, among the foreign born, Latin American females (from South and Central America) were found to have the highest rates of abstention (74 percent), followed by Mexican females (71 percent), Cuban females (48 percent), and Puerto Rican females (45 percent). Moreover, among the U.S.-born Hispanic females, a smaller number reported abstention, particularly among the second-generation females. Apparently, in the generations following immigration, women acculturate to a society that is more permissive in its norms for female drinking than is the society in Latin American countries, where drinking by females is not condoned. On the other hand, immigrant males differ in that, prior to relocation, their drinking is marked by low frequency but high quantity. Following immigration, however, males change their pattern of drinking to show both high frequency *and* high quantity (Cervantes et al. 1990*a*). The reasons for these gender differences in AOD use both before and after immigration require more attention.

In summary, it is important for evaluators to understand the evolving role of Hispanic women in the United States. In much of social science research, Hispanic women are cast as suffering wives and overly nurturant mothers who are rarely visible because of their "super macho" fathers or husbands. This image is changing considerably with the emergence of research by women, which is showing us that many of our previous images of Hispanic women are inaccurate. More important, we have a new understanding about women as single mothers and about the dilemmas posed by poverty and lower-class status. However, we lack information about how life stresses in the case of some women result in marked AOD use and abuse. Thus, in beginning to understand gender-related differences in AOD use, the evaluator must also recognize the importance of acculturation in determining how to measure changes in behavior.

Immigrants

The study of the migration of people across international boundaries is an area that has taken on new importance to social demographers and social scientists over the past decade. The phenomenon of immigration is worldwide and is usually associated with the movement of people from Third World countries to the most industrialized nations of the world. The profile of the United States, as we have discussed earlier in this chapter, has been profoundly changed by the infusion of people from Latin America.

To understand migration, it is worthwhile to make several distinctions. The first has to do with voluntary versus involuntary immigration. In the case of voluntary migration, the individual decides to migrate to a new country and usually has a reasonably well-delineated rationale to justify the move. In the case of involuntary migration, the person essentially *must* migrate because of familial, social, or political circumstances. For instance, individuals who fear for their lives and who leave their country are considered involuntary emigrants. Often they are called refugees. In addition, children and wives can be considered involuntary participants in the migration to a new country (Salgado de Snyder 1986) because fathers and husbands are the prime decisionmakers regarding immigration. The significance of this distinction is that voluntary emigrants are generally seen as adapting more readily to their adopted country than involuntary emigrants or refugees.

The second distinction has to do with the legal status of a person's immigration. Clearly, legal immigrants have an easier time adapting to a new country because their presence is sanctioned and they are granted all privileges of legal status. Illegal or undocumented immigrants, on the other hand, have to cope with and adapt to an often hostile environment. Because undocumented immigrants have no legal rights in the United States and can be deported if apprehended, these immigrants, who today include a sizable population of newcomers from Latin America, are the least likely to seek public services. Yet because of their precarious situation, these individuals are often the population at greatest risk for AOD use and abuse problems. Evaluators should properly attempt to inquire of service providers whether the services rendered are directed toward undocumented Hispanics. Further, they should try to determine whether there are differences in expected outcomes between those Hispanic immigrants who are in this country legally and those who are not.

Because of its geographic location, California is the port of entry for most immigrants from Latin America. The largest concentration of these newcomers consists of Mexican and Central Americans (Hayes-Bautista et al. 1988). But, these immigrants, while sharing a number of important characteristics, differ significantly in their life conditions and experiences before migration. For instance, many Central-American immigrants are likely to have been exposed to violence, political turmoil, and warlike conditions in their countries of origin (Cervantes et al. 1989). Further, because of the situation surrounding their decision to leave their country, some Central Americans are considered involuntary immigrants and may also hold refugee status. On the other hand, Mexican and other emigrants from Latin America relocate to the United States voluntarily with the goal of improving their economic situation and that of their families, of furthering their education and improving their employment opportunities.

The process of migration usually involves relocation to an unfamiliar environment where many of the cultural norms, values, and behaviors acquired in the country of origin no longer apply. It has been proposed that migration, especially across national boundaries, involves a number of stressful experiences. Such experiences have been conceptualized first as culture shock (Berry 1980), followed by acculturative stress (Padilla 1980), and then by cultural fatigue (Guthrie 1975). The stressful experiences originating from the encounter of two different cultures are likely to cause confusion and uncertainty in the immigrant who is poorly prepared to meet the new culture. These effects may persist until the immigrant becomes familiar with the host culture and incorporates it, along with the culture of origin, into an integral approach for living in the new country.

In the general literature on cross-cultural mental health, migration in and of itself is identified as a source of stress for the individual (e.g., Cervantes et al. 1989; Cohen 1987). Studies with Hispanic immigrants have consistently revealed a positive relationship between immigrant status and such mental health indicators as depressive symptomatology (e.g., Salgado de Snyder et al. 1990; Vega et al. 1985). The relationship among these variables is even stronger for adult female Mexican immigrants than for the general U.S. population and other later-generation Hispanics (Golding and Karno 1988; Salgado de Snyder 1987; Vega et al. 1986).

The immigrant is at high risk for experiencing severe bouts of psychosocial conflict because of self-imposed pressure to succeed and the lack of English proficiency. In addition, having left behind family, friends, and acquaintances who constituted a support system, the immigrant often finds him- or herself isolated and without anyone to turn to during periods of stress. Thus, the process of adult migration from Latin America to the United States is an important research area because there is still little that is known about the difficulties of breaking lifelong ties with family members, friends, community, and cultural forms of acceptable behavior. Specifically, very few studies have looked at the nature and content of specific areas of conflict in an immigrant's daily life, such as marital problems, concerns associated with learning English or holding a steady job, and the impact of these psychosocial stressors on mental health status (e.g., Cervantes et al. 1990*b*; Salgado de Snyder et al. 1990; Szapocznik et al. 1986).

Szapocznik and his collaborators (e.g., Szapocznik and Kurtines 1980; Szapocznik et al. 1980) have identified problem areas in the Hispanic family stemming from the different levels of acculturation. More specifically, these researchers propose that acculturation presents immigrant families with unique problems associated with disparities in how parents and children adjust to their new environment. Their observations reveal that Hispanic youngsters acculturate at a faster rate than their parents and that these intergenerational differences in acculturation often result in the disruption of the traditional, closely knit family. Thus, these researchers have developed two specific intervention modalities for Hispanic families experiencing conflicts such as AOD abuse and family disintegration derived from intergenerational and cultural differences among its members (see, e.g., Szapocznik et al. 1989, in press).

The new intervention modalities advanced by Szapocznik and colleagues have been used successfully with Hispanic adolescents with AOD problems. The Brief Strategic Family Therapy involves time-limited, strategic, structural-systems concepts that are organized as a planned, purposeful way of diagnosing, joining, and restructuring a family from the initial contact to the first therapeutic intervention (Szapocznik et al. 1988). The One Person Family Therapy tries to attain the goals of family therapy while working with one family member. This is a unique approach that brings about behavioral changes in both the AOD-using adolescent and the adolescent's family (Szapocznik et al. 1990).

Cervantes and colleagues (1990*b*, in press) recently developed the Hispanic Stress Inventory, a culturally relevant instrument designed to assess psychosocial stress in the lives of immigrants from Latin America. Their findings reveal that the most stressful situations reported by recent immigrants from Latin America are related to occupational and financial concerns (e.g., inability to get a job, lack of proper skills, legal status, insufficient income to support a family); parenting situations (e.g., overt sexuality in the United States in contrast to the home culture, poor educational opportunities, offspring who adapt quickly and demand independence from their parents like their American peers); marital life (e.g., cultural conflicts in the marriage, spouse not adapting to American life, spouse drinking too much alcohol); immigrant status (e.g., feelings of being discriminated against, feared consequences of deportation, lack of English skills); and family matters (e.g., physical violence among family members, family members having become too individualistic, individuals being too close to family members, which interferes with their own goals). A study of Mexican- and

Central-American immigrants (Salgado de Snyder et al. 1990) using the Hispanic Stress Inventory reveals a strong relationship between generalized psychological distress, as measured by the Center for Epidemiological Studies Depression Scale, and immigration stress and family/cultural conflict. Immigrant women had significantly higher scores of generalized distress than their male counterparts.

The greater number of psychological problems experienced by female immigrants may be explained by two factors. First, immigrant females experience greater stress from the life change events associated with family and personal issues during the migration process. Second, the impact of these multiple changes may adversely affect their mental health status more than it does that of their male counterparts (e.g., cause higher depression).

The psychological conflicts experienced by Central Americans and other immigrants and refugees who have fled from war or political unrest are considerably more severe than the problems of voluntary immigrants such as Mexicans. As noted previously, Cervantes and colleagues (1989) report a high rate of PTSD symptoms among Central Americans who had been directly exposed to war or its consequences and who migrated as a direct result of political turmoil in their country. Interestingly, many of the Central Americans who reported having migrated for reasons other than war indicated having intrusive thoughts of war-related deaths of family members or friends. The findings suggest that although self-reported reasons for migration may not reflect the experience of trauma that would give rise to PTSD-related symptoms, these individuals were, nonetheless, indirectly affected by war. It is known that victims of extremely traumatic events may deny or dismiss the personal effects of such experiences.

In conclusion, there is still much that we do not know when it comes to understanding the process of psychosocial stress and migration. Clearly, we recognize that gender differences are important, as are the conditions (voluntary versus involuntary) that compel people to move from one country to another. However, the evaluator will note that we have not commented at all about the effects of migration and psychosocial adaptation on

Hispanic children and adolescents. This is because this information is largely absent. Accordingly, the evaluator must be especially cautious when evaluating a program designed specifically for immigrant youth and their families.

Children and Adolescents

Hispanics are a youthful population—approximately 35 percent of all Hispanic individuals in the United States are under the age of 18 (U.S. Bureau of the Census 1990). Because of poverty, immigrant and/or ethnic/racial status, and possible prejudice and discrimination, youthful Hispanics are at high risk for experiencing many psychosocial stressors that may reduce their opportunities for success. Mexican-American and Puerto Rican youngsters in particular have very high school dropout rates, in some communities approaching 40 percent. Because academic difficulties that include leaving school prior to graduation are related to such behaviors as AOD use, any study with adolescents should assess how the individual is doing in school.

Prevalence studies of AOD use using the annual High School Senior Survey show that the use of alcohol and other drugs is alarmingly high among all adolescents (Johnston et al. 1991). However, it is difficult to estimate the prevalence of AOD use specifically for Hispanic youth because of the high dropout rate from school, because many Hispanics are no longer in school when drug surveys are taken in class. In one of the few epidemiological studies to have tried to estimate prevalence rates of inhalant use among Mexican-American youth, Padilla and colleagues (1979) found that Mexican Americans in Los Angeles between the ages of 9 and 18 were 14 times more likely to be using inhalants. In a subsequent study, Pérez and colleagues (1980) found high rates of phencyclidine (PCP) use among a similar population. However, Mata and Andrews (1988), in a study of rural Texas communities, did not find elevated rates of inhalant use among Mexican-American and non-Hispanic youth. Thus, it is important to encourage research that uncovers prevalence rates for AOD use among Hispanic youth and that is not confounded by whether the young person is in school. In addition, community studies in widely different geographic areas where large numbers of Hispanics can be found are also necessary, as suggested by Mata and Andrews' (1988) findings.

Assuming, for the moment at least, that inhalant use is a major problem among Hispanic youth, it is generally conceded that adolescents who become involved in such behavior are more likely to become polydrug users and to have poorer behavioral adjustment in school, higher levels of deviance, greater difficulty attaining adult-role appropriate behaviors (i.e., employment, marriage), and poorer health and psychological functioning (Simpson and Chatham 1991). We also know that AOD use among youth is correlated with negative and inconsistent family interactions, frequent associations with deviant peers, low self-esteem, and poor psychological adjustment (Bonnheim and Korman 1985; Santos de Barona and Simpson 1984).

One explanation that has been offered to help understand the high AOD use rates among Hispanic youth has to do with acculturation (Padilla et al. 1980; Simpson and Chatham 1991). There are two ways in which acculturation might be operating to account for higher use rates. First, we might argue that the process of acculturation is stressful and that AOD use is a learned maladaptive way of coping with the stress of adjusting to a new culture. Second, we could posit that alcohol and other drugs are more readily available in the United States and that their consumption is the expected norm among all youth.

Researchers and service providers who work with models of behavior based on premises of risk are much more likely to emphasize a stress-coping approach to intervention and prevention. They are also more likely to seek ways to prevent or reduce stress by teaching adolescents more adaptable forms of behavior. Such programs teach and encourage adolescents to try a wider range of healthy coping responses to deal effectively with their environment. On the other hand, parents say that one of the greatest stressors for them in this country is the widespread availability and acceptance of AOD use by adolescents. Parents believe that similar problems were not as widespread in their country of origin (Padilla et al. 1988), and they indicate that their greatest fear is that their children will experiment with alcohol or other drugs. Many parents also state that, because of their work schedules and the absence of a social support system, they are not always able to monitor their children as much as they feel is necessary in this country.

According to this later perspective, AOD use is not due to acculturative stress so much as it is due to the ready availability of alcohol and other drugs and the conformity to their use by Hispanic youth. It is the parents who indicate frustration in their own child-rearing practices because of the difference in values and morals in the United States. Adult Hispanics are likely to say that, although there are many advantages to being in this country, there are also disadvantages, a major one being the difference in values, which leads to a youth-oriented society that includes early AOD use. Differences in values are a major source of stress for Hispanic parents, especially immigrant parents. Although low-acculturated Hispanic parents expect their children to behave according to the traditional standards of behavior, they soon realize that their norms are no longer valid in this country. Parental expectations and the adolescent's actual behavior may result in the disruption of the traditional, closely knit Hispanic family. This, in turn, may culminate in behavioral problems, including AOD use.

In an innovative study, Simpson and Chatham (1991) and their colleagues in a special issue of the *Hispanic Journal of Behavioral Sciences* report on a longitudinal study of Mexican-American adolescents involved in inhalant use. The study examines background characteristics of the adolescent inhalant users and their success in breaking themselves of their addictive behaviors. More studies that emulate the Simpson and Chatham report are required before we can better understand the dynamics necessary to plan effective prevention and intervention programs for Hispanic adolescents.

In conclusion, the evaluator needs to be able to understand these and other perspectives to work successfully with Hispanics. The evaluator also needs to find strategies to incorporate alternative explanations when trying to understand complex behavioral phenomena and program outcomes. Just as there are two sides to any story, there are multiple interpretations that can be offered for AOD use by Hispanic youth. These differing perspectives also have different implications for the design and implementation of prevention and treatment programs. Finally, the evaluator needs to incorporate ways of assessing differences in gender when deciding on outcome measures, given that differences between male and female adolescents involved in AOD use are still not very well understood.

Conclusions

The information in this chapter was selected and organized for the culturally competent evaluator and is intended to serve as a brief guide to Hispanic cultural diversity. The demographic, cultural, and social characteristics of Hispanics in the United States described here emphasize the dimension of diversity among the individuals grouped under the generic name of Hispanics. Mexicans, Cubans, Puerto Ricans, Central Americans, and other Latinos differ from each other in terms of national origin and sociodemographic characteristics such as education, income, labor force participation, and fertility rates, as well as in some important cultural aspects. These differences are partially the result of the initial historical conditions under which the different Hispanic groups migrated to the United States, as in the case of Cubans and Central Americans, or to their established residence in a territory that was later to be annexed by the United States, as in the case of Mexican Americans and Puerto Ricans. Moreover, the sociohistorical context of each Hispanic subgroup is different, and this also is reviewed for the evaluator wishing to become familiar with Hispanics.

Within each subgroup, three important populations were identified as deserving special attention: women, immigrants, and adolescents. The stereotypical notion that Hispanic women are submissive and passive is gradually changing, and the status of women is improving. However, because of the social and economic conditions that define their lives, Hispanic women remain vulnerable and at greater risk for experiencing psychological distress.

Numerous male and female immigrants from Mexico, Central America, and other Latin American countries cross into this country every day. These immigrants have left their country voluntarily, out of a desire to prosper and succeed, or involuntarily, pushed out of their country as a result of internal warfare. The problems Hispanic immigrants experience in the United States are similar across groups except for the fact that the problems may be more severe for those who left their countries involuntarily. For example, data show that women and children, if moved against their will, are especially prone to suffer psychological stress and trauma. Similarly, refugees escaping political turmoil or open warfare are likely to show signs of PTSD. Overall, research in this area has consistently revealed a relationship between immigration and mental health status.

Hispanic youth is another population considered to be at risk for the development of mental health-related problems, especially those involving alcohol and other drug abuse. Hispanic youth are surrounded by conditions that are detrimental to their well-being, such as poverty, single-parent families, prejudice, and a lack of educational opportunities. Inhalant use seems to be the major AOD problem among young Hispanics, and along with it is low self-esteem and poor psychological adjustment.

We hope the information conveyed in this chapter will help the evaluator to be knowledgeable about the needs of Hispanic clients. We have deliberately presented information on sociodemographic and cultural characteristics because we believe such information lays the groundwork for understanding other aspects of Hispanics. For instance, by knowing something about the historical origin and demographic characteristics of Hispanics, it is easier to have an insider's view of their cultural orientation and ethnic identification. This perspective also enables the evaluator to determine how Hispanics evaluate their position in society, as well as whether they are satisfied with their social gains or frustrated by the discrimination and social oppression that they believe leaves them helpless. This alienation may, in turn, be a precursor to AOD abuse. Finally, the success of AOD use and abuse prevention and intervention programs may be determined by how well Hispanics recognize the value of maintaining an AOD problem-free environment for themselves and their community.

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6

American Indians and Alaska Natives: Changing Societies Past and Present

Candace M. Fleming, Ph.D.

Abstract

Like American society as a whole, contemporary American Indian and Alaska Native communities are facing a host of life-threatening ills, including racism, poverty, acquired immunodeficiency syndrome, child abuse, and alcohol and other drug use. Many of these threats have resulted from centuries of change forced on Indian and Native societies. For many people in these societies, such change has meant tremendous losses of culture, dignity, and life. In an attempt to depart from lifestyles and situations that compromise well-being, Indians and Natives have begun to identify for themselves culturally congruent values and behaviors that enhance life for the individual, the family, and the community. New programs seeking to change individual and collective attitudes and behaviors are being developed and implemented in "Indian country." And with the lives of individuals, families, and tribes at stake, Indians and Natives have welcomed the evaluation of these programs. However, evaluation approaches that do not consider the history and culture of each Indian and Native group may impede progress toward the goals that these communities so urgently seek.

This chapter provides an overview of the major cultural dimensions of Indian and Native societies, past and present. These dimensions address individual, family, and societal issues, and illustrate the rich diversity of American Indian and Alaska Native culture. This background serves as a framework for the following chapter, which offers specific guidance for the development of a culturally and technically competent evaluation process for American Indian and Alaska Native programs.

Introduction

For decades, millions of Americans and foreign visitors, eager to see the premier showcase of our Nation's history and lifeways, have visited the Smithsonian Institution. Although America's first citizens, the American Indians and Alaska Natives, have had a place within the Institution, until recently that place has been—regrettably—within the National Museum of Natural History. As one American Indian put it, "Indians are with the dinosaur bones because American society thinks we are extinct." Finally, in the early 1980s, the National Museum of American History established an office to address museum programming that accurately portrays the role of American Indians and Alaska Natives in American history.

This major oversight on the part of an esteemed American institution is but one of a hundred examples in which the 19th-century romance of Indian beads and feathers has served to perpetuate the notion of Indian culture as monolithic and static, even into contemporary times. Nearly all present-day Americans have definite ideas about our country's indigenous peoples. The Indian population of 1.5 million persons is so dispersed and geographically isolated that few non-Indians today have had any significant direct contact with Indians, and the romantic views continue unchallenged.

In his chapter in the book *Eliminating Racism*, Joseph Trimble (1988) examines several important factors that have fed racist and prejudicial practices toward American Indians; most of these factors are discussed here. With respect to one factor, research on the American Indian undertaken by social scientists and humanities scholars, he concludes that most of this research has overemphasized and given credibility to selected negative beliefs about American Indians. Although the goal of this research has been to find explanations and solutions to devastating problems, Trimble asserts that the continued focus of social scientists on the alarming rates of self-destructive behavior subtly serves to promote the public image of the Indian as "drunken" and "suicidal." A balanced treatment of American Indians and Alaska Natives also needs to focus on the resiliency, strengths, and numerous significant contributions these people have made and continue to make to other societies of the world.

This chapter seeks to reveal the significant dimensions of strength, integrity, and vitality of American Indian and Alaska Native people, as shown in their diverse societies. Attention is given to the historical context within which Indian and Native societies have been addressing issues of great importance to their survival as tribes, communities, families, and individuals. These perspectives are found in many forms of written literature, including poetry, plays, and novels, as well as legal summaries, historical accounts, and scientific reports. The works of such contemporary Indian writers as Leslie Silko, James Welch, Louise Erdrich, and Michael Dorris are commended to the reader. (Specific works of these individuals are cited in the reference list.) But while background reading is important, direct dialogue with Indians and Natives themselves is the most useful way to gain more knowledge from regional and local points of view. The value of investing oneself in personal relationships of this nature cannot be overemphasized.

Demographic Descriptions

During the time before contact with Europeans, it is estimated that there were about 2.5 million indigenous people representing over 300 distinct tribes in what would become the United States. Yet, by 1890, the year in which the Wounded Knee Massacre occurred, only 250,000 of this population remained. This 90 percent reduction in population resulted from several major factors, all of which were partially supported by Federal policy concerning "the Indian problem": disease, malnutrition, and war and murder. Given the active attempts to exterminate them or remove them from their traditional lands, relocation policies, extreme poverty, deployment of their young people to boarding schools, and the introduction of alcohol and other drugs, the resiliency of many tribes is remarkable.

At the turn of the last century, there were 220,000 American Indians and Alaska Natives in the United States; the 1980 census indicates that this population numbered approximately 1.5 million, nearly double the 1970 count (U.S. Department of Commerce 1983). This exceptional increase is partially due to improved health care for all ages and to an accelerated birth rate. The current birth rate among Indians and Natives is twice as high as that of the country at large.

The 1980 census asked the populace to self-identify according to ethnic background, and so the recent increase in the Indian/Native population also represents a greater acceptance of being identified as Indian. Although there is no direct evidence of the reasons underlying this change, it probably is rooted in four additional factors: (1) the increased benefits from being included as an Indian in tribal roles, (2) the benefits of being identified as a member of an ethnic/racial population in seeking employment, (3) a somewhat lessened prejudice against Indians in society, and (4) a resurgence of Indian identity and pride (Oetting and Beauvais 1989). In 1980, the Census Bureau also used more complete, consistent, and sensitive strategies for counting American Indians and Alaska Natives.

In the United States, the terms *Native American*, *Indian*, and *American Indian* are commonly used and have been considered interchangeable when referring to aboriginal people of the continental United States, i.e., American Indians, Eskimos, or Aleuts. Currently, the term *Native American* is out of favor with many because, in addition to the above three groups, it can also include natives of Hawaii and descendants of immigrants from other nations who have settled in the United States. "American Indians and Alaska Natives" is the preferred form because it is more precise in its reference. This combined form, however, is somewhat unwieldy, so the terms *Indian* and *Native* are used interchangeably in this chapter to refer to American Indians, Eskimos, and Aleuts.

Heterogeneity

The diversity found in 512 federally recognized Native entities and in an additional 365 State-recognized Indian tribes defies distinct categorization (Manson and Trimble 1982). Each of these entities has had a unique set of social, religious, economic and legal-political relationships with other tribes, other ethnic/racial groups, and Euro-American societies. Thus, there is tremendous variation, even within the same geographical region, in how Indian and non-Indian cultures find expression in the lifeways of Indian families, communities, and tribes.

Geographical dispersion is another manifestation of the existing cultural diversity. As of the 1980 census, only seven U.S. States (Arizona, New Mexico, Oklahoma, California, North Carolina, Alaska, and Washington) had an Indian population of more than 50,000 persons. Over the past three decades, American Indians have become increasingly urbanized, thereby decreasing the population density that was at one time a hallmark of the rural reservation and Indian community system. (In 1980, only 24 percent lived on reservations.)

The indexes of illness or dysfunction experienced by a group (e.g., illiteracy, the school dropout rate, poverty, unemployment, substandard housing, delinquency, arrests, mental health disorders) and the counterpart indexes of health and function are found in differential rates across and within tribes. For example, overall Indian rates of alcohol and other drug abuse are high, but prevalence varies tremendously from tribe to tribe and by age within tribes (Mail and McDonald 1980; Oetting et al. 1980). On the positive side of the ledger, several tribes are very successful in managing natural and human resources, and this success has led to life-enhancing conditions in sections of their communities.

American Indians and Alaska Natives are very proud of their diversity. It must be recognized, however, that an exclusive attention to intertribal differences has contributed to a lack of cooperation across tribes. But without the coalitions that unite diverse tribes around common concerns, many small and geographically dispersed Indian and Native communities would continue to be politically and financially disenfranchised. The future for Indians and Natives may benefit from greater attention to the concept of "unity within diversity," but when it comes to beliefs and cultural practices, tribal communities are not likely to become homogeneous. Therefore, the need for tribally specific information will continue to exist.

Language and Dialect Issues

More than 200 distinct languages are currently spoken by Natives in North America. These languages reflect totally distinct language stocks, many of which are as dissimilar as are English and Chinese (Chafe 1962). Yet as varied as Indian communities have been, they share the common experience of the almost wholesale suppression of the use of their language through policies and practices imposed by various government and educational systems. Some languages have been devastated and obliterated through this "linguistic oppression" (Medicine 1987); others have been less affected and are still being used widely among contemporary Native peoples.

Medicine (1987) describes how adopting English has meant losing the linguistic symbols of culture and gaining new biases (e.g., the male bias being one) that are carried by the semantic system of English. There are also kinship terms in Native languages that serve to depict social and familial relationships in those societies and that have no equivalent terms in English. As a result, there has been much pressure to accept new kinship models imposed by the general culture. Medicine further posits that Indian men and women have been affected by linguistic oppression differently, a cultural change phenomenon that has resulted in gender-role differences in the socialization of children, the evaluation of language use, and the mediation between Indian and White societies.

Effects of Immigration and Migration

It is popularly held by non-Indians that nearly all American Indians, including the Mayans, Incas, and others spread throughout North, Central, and South America, are descendants of bands of immigrants who walked across what is now the Bering Strait from Asia 15,000 to 30,000 years ago. Those who arrived much later include the Eskimos and Aleuts of the Arctic rim, the Navajos, and the Apaches. Thus, indigenous peoples of the Americas are often called the "First Immigrants." Indians are less inclined to discuss evidence supporting the Bering Strait theory or other theories than they are to share their own tribal creation stories. It is in these stories that one finds reference to the movement of tribal peoples not only across physical lands but also through spiritual dimensions. To most Indians, the spiritual journey of a people is as important as the geographic journey.

With the arrival of non-Indians from Europe, the tribes of the Eastern States became the "First Emigrants," leaving their homeland in search of land that would support their subsistence lifestyles. By 1700, as furs, game, and land became scarce for them, most Indians were forced west of the Appalachians. Indian resistance escalated greatly from 1850 to 1890, during which time many wars were fought and many treaties broken or amended. Four centuries of crisis-oriented Native American-White relations and of shifting homelands for the Indians finally resulted in the reservation system established in the late 1880s, in which the tribes were settled on reservations.

This period of American Indian history saw an immensely ambitious educational crusade that drew the United States Government and Christian missionary societies into partnership to bring White American education to Indian children (Coleman 1990). In many cases this meant a sojourn off the reservation for months, even years at a time for children as young as 6 or 7 years old. Both secular and religious educators held the absolute conviction that Indian people were doomed to extinction unless they were civilized, Christianized, and assimilated into White society. Thus, the process of deculturation out of the "savage" ways of life proceeded hand-in-hand with enculturation into an alien world for thousands of Indian children. Indian youth who experienced education in these settings did so with varying degrees of success, and there are many today who believe that negative sequelae associated with this period of assimilationist education are still being felt by succeeding generations.

During the 1950s, the Bureau of Indian Affairs, a Federal agency, implemented the Relocation Program to create pathways to job training and gainful employment that did not exist on reservations or in rural Indian communities. Thousands of Indian families moved to urban areas such as San Francisco, Chicago, Minneapolis/St. Paul, Cleveland, Dallas, New York, and Boston. Although centers for the provision of health and social services to Indians are found in these metropolitan areas, the Federal, State, and tribal governments have often overlooked this sector of the population when establishing public policy and social programming.

Unlike mainland Indian groups, Alaska Native groups have experienced settlement by non-Natives coming in a series of waves, beginning in 1741 with the landing of Vitus Bering, who acted on behalf of the Russian Government. Mohatt and colleagues (1988) summarize the European contact that followed: The discovery of millions of sea otters led to the subsequent Russian colonization among the Aleuts (1750–80) and the Coastal Indians (1775–1800). The Southern Eskimo also made contact with the Russians in the 1780s, and when American whalers began traveling through the Bering Straits in the 1850s, both the Southern Eskimo and the Northern Eskimo communities began their contact with them. However, except for some interaction with Russian traders, the Eskimo and Interior Indians living on the mainland were not heavily influenced by non-Natives until the 20th century.

For Alaska Natives, the most abrupt introduction to the technology of the Western world came in the early 1960s. Even though Alaska Natives experienced cultural oppression in many forms before then, a number of events at that time—such as the discovery of oil and the passage of the Alaska Native Claims Settlement Act, which created Alaska Native corporations—accelerated the change process dramatically.

Currently, more than half of the American Indian and Alaska Native population resides in suburban and urban areas. Many thousands more may use the reservation as a principal residence but spend varying amounts of time away as they seek education, employment, or respite from stresses in their home communities. It is not uncommon for urban Indian families to make several trips per month to and from reservation settings to participate in family and tribal events or to renew their strong attachment to their homelands. However, it must be kept in mind that, whereas many urban Indians are well-educated, middle-class people, there is perhaps a growing number of Indian individuals and families who are among the urban homeless and whose unique needs must be urgently addressed in a consistent and sensitive way.

Cocultural Dynamics

The Euro-American Response to Native Peoples

In his chapter addressing stereotypical images of American Indians, Trimble (1988) summarizes the predominant Euro-American responses to the Native peoples of North America over the past 500 years. He begins by stating that one radical perspective tends to portray all European colonists and their descendants as murderers and destroyers of Indian cultures. But although one can be sympathetic to the overwhelming and immeasurable losses that ensued from those first contacts, Trimble reminds us that many early Europeans approached the Indian people in friendship. There was an awareness that Indians held knowledge about the New World that would contribute to the colonists' survival. When more land was needed for the flood of European settlers, however, this brief period of accommodation quickly gave way to one of competition with the Indians. Although the official approach to resolve the competition was through the negotiation of treaties with tribes, the policy that was put into action most often was that of extermination or genocide.

By the mid-1800s, policies of extermination gave way to the strategies of relocation and isolation. Reservations were established on lands west of the Mississippi. Large numbers of Indians were forced to relocate to these lands, which were devoid of spiritual and cultural significance and were, in many cases, incapable of supporting their subsistence lifeways. The contiguous or nearby placement of tribes who had no history of peaceful coexistence created great tension between tribes as well as across Indian-White groups. With the turn of the century, the policies of pluralism and assimilation stirred the hope that the "Indian problem" would go away when Indians forsook their ways of life and blended in with the dominant culture. But somehow these positions did not lead to total assimilation for many Indians, nor did the American society embrace, honor, or nurture diversity among its peoples. One reason for this is set forth by Trimble (1988):

> *[B]eneath the fabric of the Indian ethos was an enduring sense of dignity and reverence for traditional custom, legend, and spiritualism. This ethos somehow transcended all efforts to control and regulate it, and it managed to bring the Indian into the twentieth century amidst paternalism, poverty, fear, hatred, and frustration (p. 184).*

One major acknowledgment that Indian societies would continue to endure came in 1924, when the U.S. Congress conferred full citizenship rights to all Indians. However, these rights were not immediately granted in many State and local jurisdictions, and today there continue to exist many court cases that challenge individual Indian rights. The fact that many Indians hold both U.S. and tribal citizenship has also created unique civil rights issues, which continue to be inconsistently and inadequately addressed. An example of this is the April 1990 U.S. Supreme Court ruling on *Oregon Department of Employment* v. *Alfred Smith*. The *Smith* case challenged the constitutionality of an Oregon drug law that exempted the religious, sacramental use of peyote (Moore 1990). The Native American church, which claims over 250,000 members nationwide, considers peyote as an essential sacrament, the physical embodiment of the Great Spirit. The Court held that a member of a religious faith may not challenge under the free exercise clause of the First Amendment to the

United States Constitution a legislature's enactment of otherwise general application which produces infringement on a particular religious practice. Many view this rule as a great blow to American Indian religious freedom under the First Amendment.

A termination policy proposing the elimination of treaty responsibilities with federally recognized tribes was promoted in the 1940s but not widely implemented. Gradually, tribes actively began to pursue their rights to govern themselves in a distinctly different partnership with the Federal Government. This policy of self-determination is the hallmark of the contemporary relationship of American society with Indian tribes, yet it has not been consistently interpreted. A case in point is the May 29, 1990, ruling by the U.S. Supreme Court (*Duro* v. *Reina*), which holds that Indian tribes have lost their inherent power to exercise criminal misdemeanor jurisdiction over Indians who commit criminal misdemeanors on tribal lands but who are not members of the tribe upon whose reservation the misdemeanors were committed (DeCoteau and Anderson 1990). Legal strategists advocate a congressional amendment, which could delay the enforcement of this ruling, allow for the development of comprehensive legislation addressing the jurisdictional void that the ruling has created, and reestablish tribal sovereignty in this area. (For more information about Indian law, contact the Native American Rights Fund, 1506 Broadway, Boulder, CO 80302.)

The battle for Indian rights on several fronts has been viewed by some as a diminution of non-Indian rights. Some non-Indians distrust Indian legal power and feel that reverse discrimination—i.e., discrimination against non-Indians—would result. Various non-Indian organizations have been formed to address this concern. Among other outcomes, these groups advocate the termination of the Federal Government's responsibility to tribes.

However, the Indian Self-Determination and Education Assistance Act of 1975 (Public Law 93-638) thoroughly established the mechanisms whereby federally recognized American Indian tribes are empowered with freedom to plan and implement a wide range of health, educational, and social services for their members. Thus, many tribal communities are implementing community-controlled and community-empowered strategies to address their own needs, use their own resources more fully, and pursue active partnerships with outside resources. Through formal and informal avenues, communities are seeking sober leadership, the healing of dysfunctional families, and the breaking of destructive cycles of behavior. To maximize this readiness to pursue community-wide health through self-determination, the themes of effective communication, cooperation, coordination, and inclusion must permeate every aspect of program planning, implementation, and evaluation.

The Indian/Native Response to Euro-Americans

Whereas initially Indians were open to accommodating the presence and contributions of European settlers, it quickly became evident that the very survival of the Indian nations was at stake. The desperate measures of fight or flight were often seen as their only options. Attempts to enter into a nation-to-nation relationship were met with paternalistic policies of the U.S. Government, which many believe shaped a massive dependency of Indians, individually and collectively, on the Government. This forced dependency has fostered a plethora of unsuccessful coping styles, which include passivity, alcoholism, denial of Indian ancestry, rejection of Indian culture, and inter- and intratribal strife. And from such ineffective coping has resulted immeasurable personal and social pain.

However, there are also many successful coping styles, which do not get as much press as those just mentioned. The modern warriors are those who learn the worldviews of non-Indians and can battle in the courtroom, the classroom, the clinic, and the community on behalf of Indians. The contemporary "educated Indian" also actively seeks and applies tribal knowledge and skills to contemporary lifestyles, thereby honoring tribal worldviews.

Core Elements of Culture

Cultural Identity

It has already been shown that American Indian society is pluralistic. In fact, "tribal identity" is a more useful way to operationally define cultural identity. The first self-identifier for Indian people is usually membership in or affiliation with a specific tribe or tribes. For many, the next most salient identifier is membership in a clan or society within a tribe. It is important to realize that a great concern among many Indian people is the fear that identification with a non-Indian culture is equivalent to the loss of one's Indian culture.

A large proportion of the scientific literature concerning the psychosocial issues of American Indians addresses Indian identity. An important contribution to this line of inquiry is the research of Oetting and Beauvais (1990), who tested the theory that identification with different cultures is orthogonal, that is, instead of cultures being placed at opposite ends of a continuum, this theory holds that cultural identification dimensions are independent of each other; thus increasing identification with one culture does not require decreasing identification with another.

Belief Systems

Each tribe has had its own unique set of beliefs which have been influenced by contact with both non-Indians and other Indian groups. Therefore, there are hundreds of belief systems held by American Indians and Alaska Natives. Most tribes seem to have the following beliefs in common (Locust 1985). However, this set of beliefs is meant to serve as a guide for further study and should not be universally ascribed to every tribe.

1. There is a Supreme Creator, and there are lesser beings also.
2. Each human is a multidimensional being made up of a body, a mind, and a spirit.
3. Plants and animals, like humans, are part of the spirit world. The spirit world coexists and intermingles with the physical world.

4. The spirit existed before it came into a physical body and will exist after the body dies.
5. Illness affects the mind and spirit as well as the body.
6. Wellness is harmony in body, mind, and spirit.
7. Unwellness is disharmony in body, mind, and spirit.
8. Natural unwellness is caused by the violation of a sacred or tribal taboo.
9. Unnatural unwellness is caused by witchcraft.
10. Each of us is responsible for our own wellness.

Other fairly common beliefs are related to Indian and Native sacred ways and practices. They reflect the desire for harmony among all parts of the cosmos: the Creator, individuals, families, communities, tribes, and all peoples of the world (Beck and Walters 1977):

1. There are unseen powers, or what some people call the Great Mystery.
2. All things in the universe are dependent on each other.
3. Personal worship reinforces the bond among the individual, the community, and the great powers. Worship is a personal commitment to the sources of life.
4. Sacred traditions and persons knowledgeable in them are responsible for teaching morals and ethics.
5. Most communities and tribes have trained practitioners who have been given names such as medicine men, priests, shamans, and caciques. These individuals, who may also have titles that are specific to each tribe, are responsible for specialized, perhaps secret knowledge. They help pass knowledge and sacred practices from generation to generation, storing what they know in their memories.
6. Humor is a necessary part of the sacred. Human beings are often weak—we are not gods—and our weakness leads us to do foolish things; therefore, clowns and similar figures are needed to show us how we act and why.

Value Systems

There are several papers that contrast the White value system to the Indian value system; for example, it is asserted that Anglos value individuality whereas Indians value the group collective. The listing of contrasts between two groups has some merit, but it also creates dualities where they do not necessarily exist. There are many Indian value systems, just as there are many White value systems. With that caveat in mind, some commonly espoused values across tribes include the importance of sharing and generosity, allegiance to one's family and community, respect for elders, noninterference, orientation to present time, and harmony with nature.

Learning Styles

The task of identifying both traditional and contemporary Indian learning styles is an intriguing one that has only recently begun to receive attention. The idea that there might be several Indian learning styles is of special interest, not only to formal educators but also to others, such as prevention specialists, whose goal is to impart important knowledge to Indian people.

The cognitive styles of the American Indian and their relationship to acculturation stress have not had the attention of the researcher or the practitioner that they deserve (Yates 1987). As it is for people in other parts of the world whose survival depends on learning the signs of nature, the principle of observation has been central to American Indians for centuries. Indian children learn by watching and listening; trial and error is likewise an honored process for learning. Additionally, societal norms have been passed down through the generations in the telling of stories. The oral tradition was the primary method of teaching values and attitudes in the traditional Indian society. The legends and stories often had highly specific meaning and involved intricate relationships. The use of symbolism, anthropomorphism (giving human characteristics to animals, gods, and objects), animism (giving life and soul to natural phenomena such as rocks, trees, and wind), and metaphors appears to have been an extremely effective method of teaching very complex concepts (More 1987). All in all, many scholars in this area agree that modern Indian children still demonstrate strengths in their abilities to memorize visual patterns, visualize spatial concepts, and produce descriptions that are rich in visual detail and the use of graphic metaphors (Kleinfeld 1974).

Unfortunately, the skills described above are not consistently valued in the White school system. Instead, auditory processing, abstract conceptualization, and language skills are emphasized. Although Indian children are capable of shifting to the cognitive styles promoted in formal education, other factors exist that compromise their achievement. Starting in fifth or sixth grades, Indian children typically do not achieve academically as well as their Anglo peers do. It is likely that, for some, the dissonance in Indian and non-Indian cognitive styles, the attendant negative feelings, and other psychosocial stressors plague the Indian child in school and other arenas of life as he or she matures into adulthood.

Communication Styles

An elder of the Salish Tribe once said, "The problem with today's Indian children is that they jump over their parents' words." This illustrates a common Indian view about verbal communication: Words are to be honored and not wasted. Conversation is seldom idle in Indian homes and gatherings because words have power. An emphasis on observant, reflective, and integrative skills leads to communication patterns that give virtue to silence, listening, nonverbal cues, and learning by example. However, because asking direct questions is not part of the repertoire of communication skills, Indian people are often seen as passive, uninvolved, and uninterested.

Importance of Rituals and Symbols

Rituals and symbols are omnipresent in all Indian tribal cultures. More than they do for the general U.S. society, they serve as major manifestations of Indian worldviews. They also serve to promote social morality and interdependence among all creatures, including nonhumans. Rituals and symbols are publicly given honor within the full repertoire of behaviors and cognitions, in tacit acknowledgment of their underlying significance. Their meaning is expected to emerge as time and experience go on, without a lot of effort spent on explication of their significance (Tafoya 1989).

American Indian and Alaska Native cultures are rich with symbolism. The current revitalization of Indian and Native cultures centers around the rearticulation of symbols that cast new light on age-old meanings of life. Those who are actively involved today in Indian and Native community organizations are firmly committed to the belief that the presence of symbols in a community, as well as the living out of a belief in these symbols, is a measurement of the health and positive energies present in the community.

In response to why an Indian client sought him out, an American Indian psychotherapist was told, "We heard you did dreams." "Doing dreams" has been within the purview of the behavioral health sciences, which suggests compatibility between Western and Indian worldviews. For many Indian persons, great respect is given to the phenomenon of dreams and to their importance, not only to the individual but also to the family and the tribe. Thus, the significance and perceived power of rituals and symbols go much beyond the individual. Clearly, Indians are not likely to find relevance for themselves in an approach to the understanding of individuals that emphasizes facts and objectivity.

A further example is the use of the symbol of the Sacred Tree (Four Worlds Development Project 1984), which can be found in the teachings of many indigenous peoples of the world. The Sacred Tree represents life, cycles of time, the earth, and the universe. There are a myriad of meanings one can glean from the Sacred Tree; four common meanings are protection, nourishment, growth, and wholeness. Like our mother's womb, which provided nourishment and protection during the earliest days of our life, the Sacred Tree may be thought of as a womb of protection that gives birth to our values and potentialities as unique human beings. Nourishment is symbolically represented by the fruit of the tree; interaction with the tree and eating its fruit symbolize our interaction with all aspects of life that nourish and sustain our growth and development. The Sacred Tree represents the importance of pursuing life experiences that provide positive growth and development, especially inner spiritual growth. Finally, wholeness is symbolized in the unity and centering of the Sacred Tree's pole, which stands for the Great Spirit as the center pole of creation, a center for balancing and understanding ourselves as human beings.

Microlevel Social Structures

The 1980 census revealed that the "Indian baby boom" is happening now. The median age both of American Indians (20.4 years) and of Alaska Natives (17.9 years) is significantly younger than that of the U.S. population in general (30.3 years) (U.S. Department of Commerce 1983). Only 10 percent of Indians and Natives are aged 55 and over, a statistic that emphasizes the fact that the many very young families will not have as many elders to provide guidance about family and tribal matters. Such an age distribution is likely to lead to intergenerational stress and suggests that a major mental health priority must be the solving of family problems (Attneave 1982).

It has also been observed that, as Indian elders pass away, the succeeding generations are faced with the responsibilities of becoming culture bearers much earlier in the life cycle than ever before. Elders have often been presented as the "unifiers of Indian families" (Red Horse 1980*a*), and each elder's death represents a tremendous loss to individuals, families, and tribes. Outside of the Indian community, however, elders are often overlooked as human resources for social programming.

Historically, the issue of gender among Indians has typically been addressed through discussions about patriarchal versus matriarchal tribal societies, an approach that tends to promote a dichotomous way of thinking about gender roles. In fact, men and women have enjoyed a variety of roles and statuses across the myriad of tribal cultures. Most of the literature suggests that the role-specific tasks and responsibilities in traditional societies were balanced between males and females and the contributions of each gender were equally esteemed. Despite the heavy emphasis in the pop literature on "medicine men," female participation in the curing arts and spiritual leadership can be historically documented.

Concerning the last few generations, both Indian men and women have been facing role incompatibility due to the acculturation process (Medicine, n.d.). The Navajo, for example, are a matrilineal society that has been experiencing a role reversal in leadership and economic patterns in some regions of the reservation. The fact that men have obtained jobs as wage earners and have emerged as leaders on the Tribal Council has created dissonance about the role identity of both Navajo men and women.

There are those who say that, in general, the contemporary changes in roles have most negatively affected Indian males, but more precise research is needed to identify those dimensions in which each gender is in jeopardy. In the current mediation between tradition and change, an emerging voice among the culture bearers is the concern that revised or revived roles for one gender not be activated at the expense of the other.

Statistically, intermarriage is occurring at a higher rate between American Indian women and White men than it has for unions between Indian men and women from other ethnic/racial groups (John 1988). Some of this is related to migration to urban and suburban areas, which increases the opportunities to meet persons from other races. The result is that Indian parents in mixed marriages face having to nurture two or more racial identities. They also face what the dissolution of the Indian bloodline implies for succeeding generations, especially vis-à-vis their tribal rights and responsibilities. However, there is currently little guidance to be offered to these parents because such intermarriage is an often overlooked dimension of contemporary Indian families.

It is widely agreed that Native societies hold great respect for the role of the family. In most cases, Indian families are extended family systems composed of individuals who are kin and nonkin. The family systems extend not only over several communities within a reservation, but also over much broader geographical regions, i.e., across States. Affective bonding is often extremely strong, even across the miles. Yet, the incorporation of nonkin to assume family roles has been frequently observed and often misunderstood by those whose family structural patterns are different (Red Horse 1980*b*). Thus, the strengths and vulnerabilities of modern Indian extended families deserve great attention as the force of other value orientations continues to be strongly felt in rural and urban settings.

Macrolevel Social Structures

Social relationships are of great importance to most Indian tribal groups. In many tribes, the goals and needs of a group take precedence over individual preferences and considerations. This value and its behavioral conventions have their roots in what has been called the survival pact of the past (Walker and LaDue 1986). Group survival depended on cooperative group endeavor, and there was little room for individualism. Today, survival is viewed not as physical survival, but as spiritual, emotional, and cultural survival; the identity of "Indianness" is at stake. The survival of the individual is strongly related to the survival of the society. Therefore, relationships among Indians continue to hold great importance.

Today, group reference takes many forms, the most common of which are the tribe, the band, the clan, the social and religious society, and the extended family. Spiritual celebrations, Indian dances, rodeos, and encampments (e.g., powwows) that are intergenerational and intertribal in structure are very much a part of the contemporary Indian and Native social scene on college campuses, in inner-city Indian centers, and on reservations. The powwow, in particular, is an important part of conference agenda planning by Indian organizations at the local, regional, and national levels.

Groups that revolve around gambling activities are also common in some areas. For example, clubs and informal networks have been formed to play a type of guessing game called stick game or hand game. Teams travel great distances to participate in freestanding tournaments or contests that are part of other functions, such as powwows. Getting together to play bingo in bingo parlors sponsored by the tribe or a charity organization serves as an important social event for families and friends, and thus represents more than just support for a business enterprise. For many Indians, these gambling activities contain both social and spiritual dimensions.

Organized church groups are important to many Indian tribes; the origins of most such groups can be found in early missionary efforts in the late 1800s by mainstream Christian denominations. Groups that are organized around Native religions are becoming more normative; an example is the Native American church. Thus, the general concept of "community" is defined not so much by housing areas or neighborhoods but by important relationships with family, tribe, and the spiritual world.

With the establishment of modern tribal governments on the reservations, there have arisen "political communities." Outwardly, these are defined as the townships and housing districts that make up a voting precinct. On other, less overt levels, however, political communities are defined by such parameters as family of origin, blood quantum, tribal affiliation, educational achievement, vocational achievement, and standing with the culture bearers. There are those who contend that Indian people are extremely political and that a good understanding of a particular Indian group has to include some knowledge of the complex political networks that influence public policymaking of relevant tribal, State, and Federal bodies.

Class Differences

The phenomena identifying the presence of classes within a society generally have to do with educational levels, literacy rates, poverty levels, and employment status. The statistics associated with these circumstances in Indian populations suggest that many tribes share a culture of poverty and lower-class status. Unemployment hovers at about 30 percent on most reservations and ranges from a high of over 70 percent on some Plains reservations to a low of 20 percent in the case of more prosperous tribes. American Indians and Alaska Natives aged 25 years and older have an average of 9.6 years of formal education (Brod and McQuiston 1983). (This is below the national mean of 10.9 years and is the lowest of any major ethnic/racial group in the United States.) Nearly one-third of all American Indian adults are classified as illiterate, and only one in five men has a high school education (Price 1981). Dropout rates between the eighth and ninth grades in some urban areas range from 48 percent to 85 percent (Jacobson 1973) and approach 50 percent in Bureau of Indian Affairs boarding schools and day schools on the reservations (Hopkins and Ready 1978; U.S. Senate Committee on Labor and Public Welfare 1969). Only 16 percent of American Indian students who enter universities complete an undergraduate degree, compared with 34 percent of their White counterparts (Astin 1982).

The concept of class as defined above has not been one that Indian communities have embraced until perhaps just recently. Educational achievement is valued and is one marker of upper-class status, but activism on behalf of Indian rights and community involvement is becoming a more salient marker. Years ago, adherence to a traditional Indian lifestyle was equated with lower-class status because it was seen as a stumbling block to success in the non-Indian world. In parts of Indian country today, however, success is also associated with the attainment of traditional skills and knowledge; a person poor in fiscal income may be seen as very rich in cultural or spiritual resources.

Conclusion

This chapter has provided a brief description of the American Indian and Alaska Native populations, focusing on the Indians' sociodemographic characteristics, their history of contact with European cultures, and several dimensions of their culture. The great diversity of Indian and Native societies has been emphasized throughout, as has been the danger of generalizing across both tribal and rural/urban groups. Finally, this chapter has illustrated the complexity and interrelatedness of individual and group functioning for American Indians and Alaska Natives.

All of this strongly suggests that behavioral health interventions and the attendant evaluation process must be multidimensional and interactional. Clearly, we must become aware of the many factors that establish, nurture, or rupture the link between the individual and the community. Individual and collective trauma must both be addressed so that the sense of Indian and Native community is restored and nurtured.

Indian individuals, families, neighborhoods, and communities are increasingly interested in tribal revitalization as a way to overcome the pain from historical tragedies and to keep alive the language, folkways, crafts, and values associated with their tribal identities. Although there is a danger of viewing this cultural revitalization as merely going back in time to recapture, in a wholesale fashion, a "golden era" of Indian life, there are many Indian people who want to identify and maintain traditional beliefs and values that are life sustaining and life enhancing while they participate in the contemporary world. In part, this means that Indian people must confront those problems that hinder participation and create stress in the lives of individuals and families. Traditional Indian ways are being successfully used to address current social problems, as is social programming developed by non-Indian cultures and sponsored by various entities from tribal offices to Federal institutions. At the same time, there is a growing requirement among these programs for accountability through evaluation. The following chapter addresses this issue and attempts to frame the elements of program evaluation in terms that promote self-determination among Indian people.

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7

The Role of the Researcher in Evaluating American Indian Alcohol and Other Drug Abuse Prevention Programs

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Abstract

This chapter defines the role and responsibilities of researchers who are asked to evaluate alcohol and other drug (AOD) programs in American Indian communities and settings. Building on the framework provided in the previous chapter, it identifies the various conceptual, methodological, and procedural problems that evaluators may encounter in settings that are culturally different from their own. Topics such as gaining access, measurement equivalence, report writing, and dissemination of results are given specific attention. The chapter also highlights those factors that can assist in "bridging the gap" between those

responsible for designing an evaluation protocol and those charged with designing and implementing prevention programs, and concludes that evaluation planning must be integrated into the planning of AOD programs in Indian communities.

> *Evaluation is an elastic word that stretches to cover judgments of many kinds. People talk about evaluation of a worker's job performance, evaluation of a movie script, evaluation of the sales potential of a new detergent. What all the uses of the word have in common is the notion of judging merit (Carol H. Weiss 1972, p. 1).*

Introduction

As Candace Fleming (this volume) points out, there are many important cultural and socioeconomic dimensions that distinguish American Indians.*

Issues, Problems, and Pitfalls

Considering the wealth of information generated by ethnographers, epidemiologists, psychiatrists, and social workers, many Indian communities have been the target of a great deal of research, yet for many American Indians, the goals, methods, and procedures of science—and therefore of good program evaluation research—are unimportant, obscure, and unclear (Trimble 1977). Obviously, these efforts have not always worked out well. Many a well-intentioned social scientist has been and continues to be viewed as an outsider—"a predator who is using the Indian to further his career" (Maynard 1974, p. 402). A few researchers, largely because of their lack of attentiveness to a community's lifeways and thoughtways, have even been banned from continuing their work (cf. Manson 1989; Trimble 1988).

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* The terms "American Indian," "Indian," and "Native American" are currently used interchangeably to refer to people native to the United States. Although the native people of Alaska differ from native people of the "lower 48" on a number of dimensions, they are generally included under these same terms. We will follow that convention.

Because of the growing concern surrounding the presence of outside non-Indian researchers, several Indian communities in North America have established rigid guidelines intended to regulate the research process and effort. Typically, researchers must present a proposal before a tribal, village, or community governing body, describing in detail the intent, nature, and benefits of the project. Delays occur more often than not. When and if the researcher is granted permission—a type of solicitor's license—conditions are attached. These may include (1) assignment of a tribal or village member to monitor the effort; (2) guidelines concerning respondent selection procedures; (3) the community's right to review and edit questionnaires, interview schedules, field notes, etc; (4) the community's right to review and edit research reports and to restrict or prevent the circulation and distribution of findings; and (5) ownership of the raw data and findings granted to the tribe or village. These conditions may be viewed as strident; however, it should be remembered that a few Indian communities forbid *any* outside-sponsored research from occurring within their boundaries. Hence, although the intricate and complicated elements of scientific research may not be well understood, Indian communities recognize all too well that the research process *can be* intrusive and the results invidious, divisive, and scandalous.

Whether an evaluator is invited by the community to design and conduct evaluation research or initiates the effort independently, several preliminary steps must be followed if the effort is to be effective and consistent with the community's lifeways and thoughtways. Adair and Deuschle (1970) strongly make the following recommendations:

1. Those members of the donor society concerned with planned change must have a comprehensive knowledge of the culture of those for whom the innovations are designed.
2. In addition, there must be constant awareness on the part of those planning change of their own culture (or subculture), its values, structures, predilections, and biases.
3. The political structure . . . must be understood and its leadership identified and worked through (pp. xiv–xv).

Finally, any researcher, regardless of training and orientation, has an obligation to honor the generosity, hospitality, and cooperation of the community of interest.

Heterogeneity of American Indians

The chapter by Fleming (this volume) provides an understanding of the context in which research and evaluation among American Indians takes place. Perhaps the most important lesson of that chapter is the heterogeneity of Indian people. Acculturative status, degree of identity, residential status, physiognomic characteristics, language preferences, and lifestyle preferences vary considerably between and among Indian and Alaska Native people. These factors must be taken into consideration when one is planning any type of intervention program and designing an evaluation model to assess its impact. Without this understanding, the evaluator will be operating only on stereotypes and will fail to connect with the local community.

Assumptions and Chapter Organization

A few basic assumptions are in order. First, American Indians will continue to seek support for social programs that are aimed at alleviating many of the problems in their communities. Second, there will be a continuing expectation on the part of funding and sponsoring agencies that some sort of evaluative activity will be required if those programs are to receive continued funding. Finally, there has not yet been any detailed approach to conducting evaluation research that springs exclusively from Indian cultural values. Indeed, with this statement we may have encountered our first point of contention. Does the concept of evaluation even make sense from an American Indian point of view? This is, perhaps, too large a question to be resolved here.

Our intention here is to sidestep this larger question and pursue ways of applying the evaluative process, as it has evolved as a stepchild of conventional, academic-based scientific methods, to alcohol and other drug (AOD) abuse prevention programs in Indian communities, whether they exist in rural, village, or urban settings. This effort will necessarily involve a number of compromises and may lead to unresolved issues. A further goal of this chapter is to bridge the gap between those responsible for the design and implementation of AOD misuse/abuse prevention programs and those charged with evaluating them. We will try to attend to the needs and concerns of both sides and to produce workable procedures for the evaluation process to be effective.

As an organizational structure for the discussion of program evaluation, we follow the development of a prevention program and present issues that are of particular relevance to Indian communities. At points we necessarily touch on topics that are not directly related to evaluation but that are important to an understanding of the entire process. In fact, it is difficult to separate program development from evaluation, given that, if done properly, they are intricately connected, even from the beginning. It is surprising, the number of requests we get to conduct an evaluation once the program is underway or even in its closing stages. In these cases, there is usually a sense of urgency, and one gets the feeling that the program staff have suddenly realized they have forgotten the evaluation component and need it to fulfill their contract. At this point, only a patchwork design is possible and, from the perspective of further knowledge, very little can be done.

Accessing Communities

Gaining access to work in Indian communities presents some unique challenges. The issues to be discussed are important, whether the evaluator is working in cooperation with a local agency or is totally new to the community.

Barriers to Access

In the past couple of decades, numerous Federal initiatives and programs have been launched to address the human services needs of Indian people. Unfortunately, most of these efforts have followed a predictable, unproductive course, which has led to a great deal of skepticism among Indian leaders.

What happens is that periodically, when awareness is raised about a particular problem on reservations, there is a move to create funding for new programs. The recent flurry of activity surrounding such issues as acquired immunodeficiency syndrome (AIDS) prevention, fetal alcohol syndrome, and child abuse and neglect are typical examples. Initially, there is a lot of enthusiasm for the effort, and programs are developed in many locations, often with the assistance of outside resources for planning and evaluation, such as those at colleges and universities. These programs normally operate with various levels of effectiveness until interest wanes at the funding source, monies run out, and the program dies. If patterns follow their usual course, we will see fewer and fewer initiatives in the coming years even though the problems themselves have not abated. Local human service providers, particularly at the tribal level, have witnessed endless rounds of this type of programming and quite understandably are leery of the efficacy or longevity of new programs. Those working with Indian communities must be aware of the source and nature of this skepticism.

There is also a variation on this theme that often occurs. On some reservations, there may be ongoing efforts to deal with a particular social, psychological, economic, or health-related problem. The efforts may not have high visibility, but there are local people who have invested a lot of time in them and have a personal commitment to the work they are doing. When a "new" initiative comes along to solve the problem, particularly an initiative that brings with it a good deal of outside involvement, there may understandably be a certain level of resentment. The local people who have been working on the problem may feel that their efforts have been ignored, and the implementation of a new program implies that what they have been doing has little or no value. Those who have endured several cycles of this will likely demonstrate little enthusiasm for new programs, and their lack of support could result in program failure. To avoid this, the program people and the evaluator need to have a thorough understanding of the history in the community they are working with and should work in tandem with existing service providers and resources (cf. Trimble and Hayes 1984).

A further barrier to access involves the wariness engendered by the past 400-year relationship between American Indians and the European and U.S. Governments. Fleming (this volume) has chronicled this often stormy and checkered relationship, and there is little doubt that a fully trusting relationship has yet to develop. It is important to recognize that much of the conflict Fleming describes is contemporary and very much on the minds of Indian people.

Gaining Access

Implementation of any program within a community requires some type of official sanction or alliance with a sponsoring agency. The evaluator needs to make certain that the appropriate clearances have been obtained and that the evaluation work is acceptable to the community. It often happens that the program staff feel their program is well accepted; however, should the evaluator have to venture outside the normal program boundaries for data collection, he or she may meet resistance if the right level of approval has not been obtained.

For example, in 1986, a researcher interested in collecting data from residents in a small Cree village in Canada's Manitoba Province knew in advance that the tribal leaders were reluctant to endorse his efforts. The tribal policies concerning the conduct of research by outsiders were fairly well known. The researcher stood to acquire a large Federal grant, but to obtain the funds he needed some semblance of support showing he had access to the village's adolescent population. Because the tribal leaders were not willing to endorse the project, the researcher solicited support from a non-Native local school principal. The principal complied, assuming that the tribal leaders supported the effort. The researcher received his funds and proceeded to conduct his work.

Some time later, the principal, while having lunch with a few tribal leaders, happened to mention his excitement about the research. In a matter of a few hours, the researcher and his assistants, together with their questionnaires, were summarily escorted to the reserve's boundaries. Shortly thereafter, officials at the researcher's university received a strongly worded letter essentially declaring the reserve "off limits" for anyone affiliated with the institution with an interest in conducting future research in the community.

Those not familiar with the history and structure of Indian communities may become confused by the issue of gaining access and legitimacy. For one who has worked in only non-Indian communities, the power structure and political scene can be baffling. Because most Indian tribes are sovereign political entities, it is usually necessary to gain approval for new programs and evaluation work from tribal or village councils. In larger tribes, this authority may be delegated to a council committee, often the health committee. We have seen any number of programs derailed because the tribe feels it has not given its sanction to the work. Occasionally an evaluator might believe the proper approval has been given (as in our example through the school system), only to find that people at the tribal level believe they also should have been approached. The remedy to this is a thorough knowledge of the local political and power structure.

Beyond the official levels of approval, one will often find informal gatekeepers who must be apprised of what is going to take place, and their consent must also be obtained, even if only informally. This is particularly important for programs that may be dealing with culturally sensitive material. In these instances, it is often necessary to spend a great deal of time informing local residents, particularly tribal elders, of the reasons for implementing the program, the content of the program, and the procedures that will be followed in the evaluation component. It is not uncommon for an evaluation effort to be stopped in midstream when local people protest the data collection procedures they find objectionable.

Both formal and informal approval may take an extended period of time, and this delay must be anticipated. It is characteristic of most Indian communities to make decisions by consensus—a process that cannot be rushed. If there is a sense that things are being rushed, the entire process may be delayed even further. One must also be aware that there are local political issues that must be dealt with before a final decision can be made. It is often tempting to try to become involved in the political arena in the interest of moving things along; however, this is usually counterproductive, if not presumptuous. Indeed, as Fleming (this volume) points out, the political issues in Indian communities are subtle, complex, and usually inscrutable to those who are not from the community.

The ability to conduct program evaluation in a cross-cultural setting largely hinges on the nature of the agreements that are made in the beginning regarding the conduct of the evaluation. If the community people are made to feel they are an integral part of the process and if issues they feel are sensitive are dealt with appropriately, the evaluation will proceed smoothly. Moreover, community leaders must have a sense of ownership in the effort, especially because many will be providing the data gathered by the research team.

Cross-Cultural Methodological Concerns

Generating Researchable Ideas

Prevention programs usually begin with an individual or group that develops an idea it believes is unusual or, based on its experience, more workable in a particular community. One point we emphasize throughout our discussion, however, is that any new program ideas or procedures must be thoroughly checked for cultural congruence, and this must begin even at the initial stages of idea generation. A bad idea, or one that is at odds with local values and beliefs, has no chance of success. Furthermore, the task of evaluation is nearly impossible if there are major conflicts in how a problem is conceptualized. In formulating the idea and the evaluation plan, attention must be given to the knotty problems that emerge when working with different cultures.

Equivalence of Measures

Berry (1980) has made some distinctions in thinking about cross-cultural issues that can help evaluators gain congruence between and among assessment approaches in the early stages of planning. He refers to three types of equivalence between cultures: conceptual, functional, and metric. We discuss the first two of these below and address metric equivalence further on.

To understand conceptual equivalence, one must recognize that every culture has developed ways of looking at the world that make sense to its members. This worldview, much of which is reflected in the language of the culture, has been shaped by environmental, historical, biological, and other factors that have marked that people's evolution as a unique group. While there may be commonalities in worldview, depending to some extent on the proximity of groups, there are also usually areas of significant differences. For instance, many American Indians differ from White people in their view of what mental illness is all about (Trimble and Hayes 1984). For some tribes, mental illness is the result of having in some way transgressed the rules of right living, and until this can be rectified through ceremony, the illness will continue; thus, it is a spiritual issue whose resolution is in the hands of a medicine person, or shaman. This contrasts with the White view that the person has been subjected to a pathological process that can be relieved through medication combined with the individual's efforts to change his or her behavior.

It can easily be seen how questions about mental health in one worldview would not make sense in the other. For instance, if one were to ask a very native-oriented (i.e., traditional) Indian what causes alcohol and other drug abuse and were to give that person the usual psychosocial options to choose from, most likely he or she would be at a loss to respond. For some tribal worldviews, the most appropriate response would be that the individual or a family member had broken some type of taboo and that the resulting lack of harmony with the spiritual world must be rectified through traditional medicine. Clearly, the typical kinds of questions that are asked about attitudes or beliefs among non-Indians probably would not elicit this same explanation.

The purpose or significance of an apparently similar behavior may differ across cultures; in other words, a behavioral act can be functionally equivalent yet have a different meaning. For instance, for a White alcoholic there is usually some level of shame or guilt involved in abusive drinking when family members are present. For many American Indians, however, drinking with family members is a social event, and a refusal to drink is taken as a rejection of the other family members. Thus, if the evaluator is assessing the role played by the family in alcohol use, the questions used may be tapping different social meanings. If one were to ask an Indian if that person's family encourages him or her to drink, an affirmative response might indicate close family relationships, whereas a similar response from a White person could signal serious family dysfunction.

Lack of functional equivalence can occur at even more subtle levels. Indian children are often described as being very quiet and reserved, especially in a classroom headed by a non-Indian teacher. Quite often they are labeled as being withdrawn and unresponsive, the implication being that their behavior is a form of emotional dysfunction. However, this type of behavior in Indian children has a number of other explanations including showing respect for elders (i.e., the teacher), feeling shy in an unfamiliar situation, or being unwilling to speak up lest it be seen as an attempt to show superiority over other children. An assessment of classroom behavior using the usual indicators and interpretations could lead to erroneous explanations.

In our experience, it is still very common for evaluators to move into a cultural context where they have not had even cursory experience and to expect that all their concepts and measures will have the same meaning. In most instances, evaluators do not have the luxury of being able to establish conceptual or functional equivalence rigorously across cultures. This process is time-consuming and constitutes a long-term research program in and of itself. But this does not excuse the evaluator from making an honest effort to identify the most obvious and perhaps most important areas in which non-equivalence may occur.

The key to this effort, while time-consuming, is also simple. It requires that extended discussions take place between evaluators and knowledgeable local people who are part of, or very familiar with, the local culture. The philosophy, goals, and methods of the evaluation need to be thoroughly examined from both cultural perspectives to see if there are conflicts and to adjust the evaluation process to address the conflicts, if any exist.

Specifying a Program Theme

Once an idea has been developed, the entire scope and all the activities of the program must be conceptualized. At this point, the idea is broadened and may be broken down into separate or related components. Each component must once again be examined for its congruence with local culture and values. Discussions should involve local planners, decisionmakers, and program people. In fact, some of these people could acquire firsthand knowledge of the evaluation research as the planning and conceptualization unfold. They may even identify certain areas that might be problematic. The following example reinforces this point.

A recent attempt to create an AIDS prevention program in a reservation school system was nearly derailed due to a lack of understanding of the cultural values surrounding birth control. One goal of the program was to familiarize students with the use of condoms, and an extensive curriculum module was developed. But there were very strong local beliefs regarding the use of condoms, about which the evaluation planning team was unaware. For the local people, it was legitimate to teach condom use to prevent sexually transmitted diseases but it was not legitimate to teach methods of birth control. This appeared to be a contradiction to the program developers and evaluators, but it was totally consistent with local beliefs. The community people were very concerned about disease prevention but were not willing to compromise their beliefs about sexuality and fertility. In the end, it was necessary to come to some compromise about what could be taught in the schools as well as what attitudes could be measured in the evaluation component. Much of the sexual behavior material was deleted.

As each program objective is developed, there must be concurrent thinking about how each of its components will be evaluated. This not only makes evaluation an integral part of the entire planning process but also helps to sharpen the thinking about the goals themselves. This interchange may also reveal potential points of conflict. The central task in evaluation is to determine what evidence would be sufficient to demonstrate that a program is either effective or ineffective. The usual approach to this task is to examine the program goals, seek outcomes that can be quantified, and, finally, identify measures that will yield numeric comparisons.

At every step in the planning process, however, a cross-cultural evaluation effort may encounter difficulty (cf. Lonner and Berry 1986). At the most basic level, there may be differences concerning the overall goal of a social intervention. For example, the stated goals of an AOD abuse prevention program on an Indian reservation may be to reduce the levels of AOD use among junior high school students and to delay the age of onset of AOD experimentation. This seems rather straightforward and would call for pre- and postmeasures (at the appropriate intervals) to assess rates of AOD use in the target population and determine the age of first use. Some people in the community, however, may see this as an irrelevant effort. They may be expecting the program to foster a return to more fundamental, tribal-specific values, which they believe would automatically bring a reduction in AOD use; thus, to them, measurement is unnecessary. In one respect, this disparity can be described as people simply operating at different levels of specification—one looking at broad program goals and the other looking at a more specific behavioral level. However, this disparity could also be signaling a basic disagreement about the entire purpose of the evaluation effort. A more native-oriented person may be implying that this is a moral or spiritual issue that is not amenable to quantification. Unless these differences in expectations are made explicit, conflict will continue throughout the evaluation process.

Resolution of such discrepancies in expectation is not easy and usually involves compromise. On the one hand, a native-oriented person may have to accept the need for quantitative measures of behavioral change. This type of information is valuable from one perspective and may be especially persuasive to those agencies providing the funding. In some instances a funding source may even require the use of quantitative approaches as a condition for support. However, it is also reasonable to expect that there be some judgment about whether fundamental values are being considered. For instance, it would be appropriate to have tribal elders or healers inspect the content and process of the program and give their judgment about its value in addressing cultural values and beliefs. The important point is that these opinions and judgments need to be given equal weight in the evaluation process and in the final report. This will require a change in mindset on the part of both the evaluator, who is not a member of the culture, and the funding agencies, who may be reviewing the program for refunding. There continues to be a bias against this type of "soft data" (often referred to as "subjective") among many professionals and funding sources, yet at times this might be the evaluator's most important source of information. In the final analysis, the objective measures in the evaluation of a prevention program such as that described above may show significant changes in AOD use behavior, but the tribal elders might conclude that the program activities are so contrary to cultural beliefs that the program should be scrapped. Both types of information are legitimate evaluation "data," and if either is missing, accurate judgments about program effectiveness are not possible.

Another means of ensuring equivalence is the use of local people as part of the evaluation team. It is important that these people be deeply involved with the planning and that their views be given full consideration. Too often, local people are hired as program staff, but their ideas are not sought and they are not included in planning sessions. Therefore, evaluators must be aware that many Indians interact and communicate with one another in unique ways. In meetings where ideas are being shared and plans are being made, it is common for Indian people to withhold their comments until everyone else has spoken. It often happens that meetings are ended before the Indians in attendance have had an opportunity to present their views, and an important source of information is lost. Thus, it is appropriate to make a concerted effort to solicit input from Indian staff members and to allow several minutes of silence to ensure that everyone has had the chance to speak.

A Word of Caution

Up to this point, we have given considerable attention to describing the "front end" of program development and evaluation because we believe this is where most problems will arise. Ironically, many evaluators/researchers spend the least amount of time working with these issues, believing that evaluation is primarily a technical process. We are disconcerted by the number of calls we receive from researchers who want us to "find an Indian population where I can implement this new program I just got funding for." One wonders how such a proposal ever survived the scientific grant peer review process! There is little or no understanding of the multiple points of possible incongruence or conflict that can arise at the conceptual level of program development and of the inappropriateness of bypassing the many levels of protocol. This insensitive approach also helps perpetuate the perception among Indian people that they are being "used" for research purposes, with little concern for their interests and welfare. The value flows only in one direction, seemingly to further only the goals and interest of the researcher.

Measurement Issues

We now turn our attention to measurement issues and begin with the concept of metric equivalence as described by Berry (1980). The discussion that follows, however, focuses on conceptual problems, not on techniques of measurement; excellent descriptions of the latter are available elsewhere (Oetting et al. in press; Sudman and Bradburn 1974).

The items or scales that measure constructs often operate differently across cultures. A few years back, one of us was developing a multi-item scale to measure social deviance. The scale worked well for White youth and had a very high reliability. When the same scale was used with Indian youth, however, the reliability was much lower. Some investigation revealed that one of the items on the scale was consistently interpreted differently by Indian youth. In fact, it had the opposite meaning for them than it had for White youth. The item, which asked students to rate how often they got into fights, read "I fight" and included the possible responses of "a lot," "some," "not much," or "not at all." White youth interpreted this item in the way we intended—i.e., "I get into fights." Many Indian youth, on the other hand, interpreted it to mean, "I will fight for what I believe is right." Not only did this clearly affect the scale's reliability among Indian youth but, if one were to compute a scale score, it would appear that Indian youth, on average, had higher levels of deviance than their White counterparts.

Another problem with metric equivalence occurs when the relationship between variables is not the same across cultures. In a current study, we have preliminary evidence that anger may operate differently in Indian and White students. For White students, higher levels of anger are related to higher levels of AOD use, whereas for Indian youth, higher levels of anger seem to lead to lower AOD use. It may well be that Indian young people experience a sense of anger at the many injustices they see in their world, and this acts as a positive motivator in their personal behavior. But without knowing that this difference exists between Indian and non-Indian youth, it would be easy to make the wrong interpretation about what anger means, and this might lead to interventions that are ineffective or harmful. This difference between Indian and non-Indian youth might also lead to erroneous conclusions when certain interventions are evaluated. Certain types of interventions could provoke this positive sense of anger among Indian youth. However, an inappropriate evaluation measure could lead to the notion that the program is harmful—i.e., that it leads to aggression and to a greater propensity to use alcohol and other drugs.

Although it is often ignored, establishing metric equivalence should be a standard task for evaluators. As previously mentioned, it is not enough to identify measures that have been used in other studies to measure a concept under consideration. It must be demonstrated that the selected instrumentation is both valid and reliable for the population on which it will be used. In addition to the usual reliability and validity studies, it is useful to analyze the factor structure of the measures and constructs being used. Besides establishing metric equivalence, factor structure analysis can help in examining problems that may also exist with functional and conceptual equivalence. In fact, the abovementioned problems in measuring deviance and anger were discovered through a structural analysis procedure.

The question is often raised as to whether it is best to use "off-the-shelf" measures or to construct new measures when doing evaluation in a cross-cultural milieu. There is no one answer to this question, given that problems can be encountered with each approach. But unless there is evidence that an existing measure has already worked in the population being evaluated, it is usually necessary to establish reliability and validity with that group. This is not to say, however, that all measures are inherently culturally biased and cannot be used, either in part or in whole, with other populations. For example, a scale to assess incidence and prevalence rates of AOD use, assuming no language barriers, should be accurate regardless of which population is being measured.

The construction of new items and scales is not a task that should be taken lightly. Many evaluators underestimate the difficulty of scale construction, and this difficulty is multiplied when the new scales are applied across cultures. One of the most common errors is not to test the scale before using it for evaluation. Pilot testing is an absolute requirement and should involve a debriefing procedure in which potential subjects can talk about their interpretation of the items. The many ways of interpreting a seemingly straightforward question are quite surprising. In assessing the level of perceived social acceptance among young Indian students, we have routinely used the item, "Other kids like to play with me." In the context of elementary school students, this item seems reasonable. However, at one point we tried the item with older students and received some unprintable responses. In retrospect, we felt particularly foolish for not having recognized the sexual connotations. In fact, as we looked back over our data from previous studies, we concluded that it was not even a particularly good item with younger students.

Many of the more mature ones may have seen the double meaning and responded capriciously.

One aspect of measurement that is often neglected in evaluations is the use of qualitative data. Too often, evaluators focus exclusively on quantitative methods and miss the richness of information that can accrue from other approaches. Qualitative methods, including ethnography, are particularly useful in dealing with the cultural diversity of Indian tribes, as discussed by Fleming (this volume). It is through these approaches that the subtle differences in worldviews can be discovered, and the evaluator can identify new dimensions that are not obvious or amenable to quantification. Fortunately, there is an increasing acceptance of qualitative methods from both the research community and the funding agencies.

The one caution that is in order is that sound qualitative methods be used. Evaluators who are not familiar with this area are often unaware that there are well-accepted, rigorous procedures for qualitative research that can yield reliable information. Too often, qualitative research is viewed simplistically and amounts to little more than having extended conversations with people. The best strategy for an evaluator who is inexperienced in these methods is to identify and use trained ethnographers who are familiar with the local culture.

There is one final set of points to be made in this section. Over the years, researchers working with different cultures have resorted to the use of measurement tools that are based on norms and the testing orientation of those with a Western perspective. All too often, these researchers encounter problems in administration, scoring, and, assuredly, interpretation. Critics abound, though, and a number of cross-cultural researchers have commented on the cultural inappropriateness of measurement approaches (Irvine and Berry 1983). Trimble and colleagues (1983), wondering "why some investigators, almost blindly and with utmost diligence, continue using measurement traditions" (p. 268), go on to identify seven common pitfalls in cross-cultural testing:

1. Psychological constructs are viewed as synonymous with locally derivable criteria, which may or may not be consistent with the implied intent of the construct.
2. The establishment of several types of equivalence is not considered essential.
3. It is assumed that once tests are purged of verbal material, leaving only nonverbal stimuli, they are more "culture-fair."
4. Norms gathered in one culture are used to evaluate the performance of individuals in other cultures.
5. People from around the world may have variable and different modes of responding to test items.
6. Such testing generally tends to infer deficits on the basis of test score differences.
7. Nearly all psychological tests are culturally isomorphic to the West, which can be characterized as sophisticated and "test wise."

Collecting Data and Information

Care must be taken to ensure that the actual data collection is done with consideration and respect for all elements of the community. With the emergence of numerous social service programs, it often happens that multiple evaluations may be going on at the same time in any one community. At a certain point, systems become saturated with surveys and other assessments, and resistance develops. This is not an issue solely with Indian communities, although we are aware that many people on reservations feel they are under extreme scrutiny, which gives rise to certain levels of resentment and suspicion. Schools in particular feel the pressure to respond to a variety of social problems, which they feel reduces their capacity to educate. One teacher on a southwestern reservation recently commented, "Anymore we have to teach kids everything from tying their shoes to how to put on a condom, and we barely have time to teach them to read." It will be increasingly important to keep the amount of evaluation assessment to a minimum, and such assessment must be done in a way that creates the least intrusion on the system.

One way of reducing the amount of assessment that is done for evaluation is to ensure that the distinction between basic research and evaluation is maintained. Evaluators are essentially researchers, and it is difficult for them not to ask for the maximum amount of information when a given problem is presented. However, what is "interesting" to an evaluator/researcher often has only marginal relevance to program effectiveness. This is not always an easy judgment to make, given that evaluation must often respond to both questions, "Does the program work?" and "Why does it work?"—the latter being necessary to see if the program will generalize. However, if the survey protocol becomes too long, it will jeopardize the entire data collection process. It is also important to recognize that many reservation schools have serious financial and staffing deficits, which result in poor reading skills among students. A survey package that works well for urban youth may be too complex for Indian youth.

Another assessment difficulty that may arise is that some members of the community may feel they were not consulted about the content of the assessment tools. This can never be totally averted, and there is always the potential for objections. This is particularly common in Indian communities, where decisions are made by consensus and procedures are not sanctioned until everyone has had an opportunity to voice an opinion. The evaluator must ensure that a reasonable amount of time has been given for widespread review of procedures, especially the items to which young people will be asked to respond.

The evaluator needs to visit the actual site where the program to be evaluated will be conducted, and to become familiar with the people the program will serve and with their daily operations and problems. Without this understanding, the data collection plan may be totally unrealistic. Many Indian communities are geographically isolated and lack resources that are commonly assumed to exist.

A site visit not only will give the evaluator a feel for local conditions but also will help prevent a common problem: system overkill. It is easy to build an ideal evaluation plan that, in practice, is not feasible. For example, a plan that calls for interviewing the parents of all the children in a program might work well in a city but not in a location that encompasses hundreds of square miles. In addition, many grassroots programs employ people whose personal and financial resources are severely overtaxed; thus, to ask them to commit more personal time to engage in evaluation tasks is totally unrealistic.

Data Analysis, Report Writing, and Dissemination of Findings

Data Analysis

Data analysis is generally a technical task that is often left to the evaluation team, which then presents the results to the program staff and other local groups. In a cross-cultural setting, it is advisable to include knowledgeable local people even in the early phases of analysis; it is an opportunity to gain greater insight into the data. In a recent evaluation of a mental health training program on a reservation, one outcome variable was change in the communication patterns between the staff in various mental health agencies in the communities. Based on the data, the evaluator determined that communication patterns had changed only slightly for the better in some respects but that there were certain channels that showed no change; thus, the evaluator concluded that this aspect of the program was ineffective and should be eliminated as a program goal. However, a local agency representative, who was part of the evaluation team, indicated that much of the communication in this community was governed by traditional family and clan relationships and that the approach taken in the training program had little chance of changing this pattern. Part of the issue had to do with traditional and therefore acceptable paths of communication between older and younger generations, but there was also an element of longstanding feuds between certain factions within the community. This interpretation had clear implications for any conclusions drawn about program effectiveness; communication patterns could be improved, but a different approach would be needed.

Report Writing

Fleming (this volume) discusses the negative impact that many research and evaluation studies have on the reputation of ethnic/racial communities. In large part, this is due to the way in which program proposals and evaluation reports are written. Social programs, by nature, are designed to address social ills; therefore, written descriptions focus heavily on the negative aspects of communities. When ethnic/racial communities are involved, this type of reporting—over time—tends only to reinforce negative stereotypes.

In the worst case, study results can be blatantly used to denigrate a community. Some years back, a local bordertown newspaper obtained the results of a survey of alcohol and other drug use that was given on a reservation, and it sensationalized the results. Although there were no overt racial statements, the intent was clear and the Indian community experienced a great deal of shame. Social problems do exist in ethnic/racial communities; however, it is necessary to place them in context, and any evaluation report should reflect that context. For example, AOD use problems in Indian communities largely reflect socioeconomic conditions and are not related to any inherent cultural characteristics. Indian people are becoming increasingly impatient with the litany of social ills that are ascribed to them, and an evaluation report that presents a balanced picture will get a much better reception and is more likely to be used. In a word, the report should be written and presented respectfully.

At several points in this chapter we have suggested that an evaluation may have two purposes. At the local level, people need to know whether the program has value for them, that is, is it culturally congruent, well received by the community, and consistent with local values and norms? There is also a need for technical data that support the report's conclusions and may be used to answer more specific questions. These two purposes suggest the need for two types of reports. It often happens that technical reports are never used at the local level because they are too complex and do not respond directly to the need to make decisions. In the absence of a more comprehensible document, the community may be left with the feeling that the evaluation was a wasted effort, and it may develop a negative attitude toward evaluation in general. Thus, a report written in nontechnical language specifically to address the local need is appropriate (Trimble 1977).

Dissemination

The issuing and dissemination of the evaluation report will often have to be handled carefully, particularly if the report contains sensitive information. In one sense, this is a question of who owns the data. Strictly speaking, the report is a part of the intervention program, which, in turn, is an extension of the community agency sponsoring it. Given this, the community or its representatives would have the final decision about the dissemination of results. There must also be a recognition, however, that this type of information can be useful in other communities and therefore needs to be published in some form.

Several approaches can be used to reduce controversy over publication. First, as we have stated before, these negotiations should occur very early in the evaluation process, and some general agreement should be reached. In some cases, even if prior agreement has been reached, there may be some unanticipated results that community people find sensitive and would not like to see publicized. Usually, a compromise can be reached through negotiation, whereby some information may be deleted or left in a report for internal purposes only. It is also useful to allow local people to preview the report to determine whether there are any conclusions that could be more accurately interpreted in light of local culture, values, or beliefs.

Whenever there is concern over report content, the manner in which the report is released can be extremely important. In 1980, a very sensitive report on alcoholism in a Native Alaska village was released to the general media (cf. Manson 1989). In addition to a number of other serious errors in protocol, the information from the study was presented at a press conference thousands of miles away from the village where the study was conducted. This precluded any participation by local people and allowed the whole situation to be presented out of context. Once again, an Indian community experienced a great deal of shame because the information released implied that nearly all of the Indian adults in the community were alcoholic. Although the actual situation was quite different, there was no way to moderate what was presented.

It is good practice to have local people involved in any release of information, either in person or through a cover letter signed by an agency representative. This once again demonstrates the need for community people to be intimately involved with any evaluation effort. It not only ensures that the most accurate information is presented, but also precludes the perception that the community is once again the subject of outside interventions and is not capable of resolving local issues.

Social Policy Implications

As we pointed out earlier, there is tremendous diversity among American Indians and a strong movement to preserve that diversity. While this imparts a sense of pride and integrity among Indian people, it also makes the process of evaluation very complex. To be effective, a program should be tailored to the tribe where it is offered; therefore, a program that may be effective for one tribe may be culturally irrelevant for others. If the focus is on the content of a particular program, there may be little generalizability from one tribe to another. However, we have discussed a number of process variables that have more widespread application among Indian tribes. Perhaps the most important issue is that of spending adequate time in the early stages of the evaluation ensuring that there is congruence between the values and expectations of the program staff, the program audience, and the evaluator. There must be extensive time spent ensuring that the concepts and measures used in the evaluation are culturally appropriate.

Another common theme in the evaluation of Indian programs is the need to agree on the use and dissemination of evaluation results. There must be a continuing effort to place the focus of evaluation on the value of the program and not on the value of the program staff. Too often, evaluation is seen as a way of cutting programs rather than improving them. It is important to realize that employment on many reservations is a critical issue. Unemployment rates are exceptionally high and jobs are greatly prized; on some reservations where housing is scarce, getting a job also means having access to a house. If program staff feel that an evaluation of their work could possibly jeopardize their job and housing, there may well be resistance. Thus, it is incumbent on both program administrators and the evaluator to create a climate of trust and a sense that the evaluation is solely for the purpose of improving the services offered.

A more general issue involves the creation of an ethic among tribal services that evaluation is an integral part of the work that is being done and not just an adjunct that is tacked on to program services. This can be accomplished by striving to involve all program staff in the process and by having them contribute to the data collection. Often evaluation is perceived as some elaborate technical enterprise that can be conducted and understood only by experts or outsiders. In truth, at one level, evaluation is nothing more than pulling information together to form some sort of judgment about the efficacy of a program. Using this broad framework, anyone on the program staff can contribute to the evaluation effort. There is often an extensive amount of qualitative and anecdotal data that can bolster an evaluation report. For example, in Indian communities the perception and judgment of elders is often critical to a program's long-term success. If the older people see it as valuable and congruent with traditional values, the program stands a much better chance of being widely accepted in the community. On the other hand, a negative perception by elders can be sufficient to terminate a program; however, without some way of detecting the attitudes of elders, it may never be known what led to the program's demise. This is the type of information that may not emerge from the formal evaluation process yet may well be accessible to the local staff.

Similarly, many programs have unintended consequences, either positive or negative, that may not be anticipated in the formal data-gathering system. Unless all staff members are alert to these possibilities and are encouraged to share them with the evaluator, such data may never come to light.

An example of an unanticipated outcome occurred some years ago on a southwestern reservation during a program intended to educate people about diabetes. Over the course of a year, community health representatives went out to remote homes and disseminated information concerning the diagnosis and treatment of diabetes. After a time, the clinic staff noted that a number of people were coming in for health care unrelated to diabetes. What had happened is that the representatives had created relationships with many of these families and had made it much more acceptable for people to come into the clinic for health problems that previously had been ignored. The important point here is that the staff were alert to this outcome and were willing to share it with the evaluators, who in turn made this information an integral part of the evaluation report.

Decisions to retain or terminate programs are often based on factors other than the evaluation data. These decisions may be out of the control of the program staff and certainly are not in the purview of the evaluator. In one instance, a training program for health workers on a reservation was retained even though the data indicated that it was not particularly effective. The reason for retaining the program was that it was a central link in a more extensive career ladder plan being implemented by the tribe. There may be a host of other administrative or political reasons for retaining or terminating a particular program. However, even in these instances, the evaluation results are still useful. We believe that administrative decisions should be made in light of all possible information, and program evaluation is certainly a critical source. Even if the final decision differs from what is suggested by the evaluation, that decision has been made on an informed basis.

This issue brings up an important administrative decision regarding evaluation: Will the results be used to help alter programs while they are operating (formative evaluation) or will they be used solely at the end of the program to determine the program's effectiveness (summative evaluation)? Depending on the purpose, different strategies will be used, and people's expectations concerning the nature of the outcomes must be congruent with the purpose. In the above health training program example, a formative evaluation would have been helpful in providing feedback that could have changed the program midstream to make it more effective. In the evaluation of another drug prevention program in which a formative evaluation was used, it was discovered through interviews that the students felt that the information they were being given was too simplistic and that they were being talked down to. Outside the classroom, the students were making jokes about the program, and it was clear that the information was ineffective. Once this was discovered by the evaluation team, the staff was able to alter the curriculum and make it more age appropriate.

At other times, it might be more appropriate to test the effectiveness of a program without trying to alter it midstream—that is, to design the evaluation so that it provides only a judgment at the end of a program concerning the program's efficacy. This would be appropriate in a situation in which the agency is trying to decide which one of a number of different existing AOD problem prevention programs would be useful in their community.

Although it has become increasingly common for Indian AOD programs to have an evaluation component, it is surprising how little use is made of the results. Currently, there is no central source where prior evaluations are available to those designing prevention programs. Unless the evaluation has been published in a professional journal, there is no access to the findings. This is unfortunate because a lot has been learned about prevention that could be useful to new programs. It would be helpful to establish a clearinghouse for evaluation results of Indian AOD use prevention programs. This would allow for more rational program planning as well as avoiding the frequent feeling that efforts are being duplicated without the benefit of valuable feedback regarding effectiveness.

Summary and Conclusions

Program evaluation for Indian AOD use/misuse prevention efforts is hardly a new idea; however, it has been applied very unevenly in the past. Some communities have taken it seriously and implemented highly sophisticated evaluation plans; others, unfortunately, have believed that a highly subjective evaluation would appease program funding sources. Nonetheless, there are a number of barriers to performing good evaluations, and many are the result of the cross-cultural issues that are involved. It is our strong conviction that evaluation needs to be an integral part of programming, but we also believe that not enough effort has been put forth in trying to forge procedures that are culturally congruent and consistent with local lifeways and thoughtways. As long as there is reluctance to confront the many challenging questions posed by this pursuit, evaluation will be seen by tribes as an irrelevant exercise and by evaluators as an impossible task. We hope we have provided some guidance whereby good evaluation can be conducted and the many valuable lessons that are being learned every day in Indian communities can be explicated and communicated.

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Cultural Competence for Evaluators Working With Asian-American Communities: Some Practical Considerations

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Abstract

This chapter presents some of the practical issues one must address when evaluating alcohol and other drug (AOD) misuse and abuse prevention programs involving Asian/Pacific Island-American communities. Specifically, the emphasis is on large-scale community-based prevention programs rather than on issues pertaining to AOD addiction treatment, which is the focus of the following chapter. In exploring this essentially uncharted area of inquiry, this chapter defines the basic premises of social science research and program evaluation theory and contrasts them with the factors that are necessary for culturally competent evaluation when Asian groups are involved. It also discusses the concept of cultural competence in prevention agencies and reviews a variety of management strategies that can improve the program evaluation process.

Introduction

The purpose of this chapter is to present some of the cultural, methodological, and research issues one must address when evaluating community-based alcohol and other drug (AOD) misuse and abuse prevention programs involving Asian/Pacific Island-American communities (for simplicity's sake, Asian groups or communities). Specifically, our emphasis is on large-scale community-based prevention programs rather than on issues pertaining to AOD addiction treatment, which are discussed by Sherman Yen (this volume). In exploring this new area of inquiry, we identify the basic premise of social scientific evaluation inquiry and examine it against culturally competent evaluation involving Asian groups.

The ultimate goal of all prevention evaluation research includes not only the statutory need to describe the outcome or impact of the particular program or project being implemented, but also the need to present directions and guidelines to refining the program in the future. It is assumed that no community-based prevention programs are either perfect or completely useless and that all such programs have room for improvement. Within this dual context of evaluative judgment and program refinement, cultural competence in evaluation is viewed as the capacity of the evaluators to acknowledge the importance of cultural uniqueness and the associated cultural specificities that either hinder or promote the AOD use of the client pool under investigation. At the same time, cultural competence also acknowledges the capacity of the evaluators to function effectively, not only with the stakeholders of a particular prevention project but also with the clients.

In determining the cultural specificities that affect the outcome of a community-based prevention evaluation project, we emphasize that no social scientific evaluation research operates in a vacuum (i.e., in a manner that is context free) and that no such research remains atheoretical. This is because all evaluation research is based on some theoretical orientations or on a set of intuitive assumptions not only about a particular prevention program itself but also about the client pool the program seeks to serve. To reiterate, all prevention programs are based on some conceptual assumptions or intuitive hypotheses, if not on a firm theoretical foundation on which the prevention strategy is grounded.

All prevention evaluations must therefore be based on a firm understanding of the workings of many factors, all of which determine the program outcome. These factors include the demographic and socioeconomic characteristics of the target populations served; the pattern of AOD use among the client pool; the theoretical currents on which prevention programs rest; the cultural specificities, values, and aspirations that affect not only the very implementation of the program but also its outcome; the high-risk factors associated with AOD abuse by the client pool; the rationale behind the selection of prevention strategies chosen by the prevention service organizations; and the organizational structure of the service agencies providing prevention services in a particular community.

Based on this contextual and theoretical information, the prevention evaluator charts the strategy needed to collect the kind of data that serve the overall mission of the project. During this phase, the evaluator must pay special attention to culturally relevant strategies and to the situational factors that must be in place to enhance both the data-gathering process and retention of the client pool. We therefore discuss culturally relevant management and logistical support strategies that promote the quality and quantity of data to be collected concerning Asian-American communities. Highlighted is an evaluation strategy that is built along the concept of the "empowerment of the process evaluation," i.e., some aspects of the process evaluation conducted "by the people for the people" within the Asian-American communities.

Based on culturally relevant data-collection strategies, the evaluator then proceeds toward the operationalization of the dependent variables that fit the professed (ultimate) goal of the program as well as the program's instrumental goals. Here we emphasize that, for every professed goal, there can be numerous lower-level instrumental goals that can be deduced from it. An understanding of both kinds of goals will also help evaluators to differentiate between program failure and theory failure. Depending on the program design effect (i.e., the scope, intensity, and duration for which the program has been implemented), it is very likely that the evaluators will have to place a limit on the kind of outcome expected of a particular prevention project. Unreasonable expectations will surely result in program failure; however, low-intensity, intermittent, short-term, and piecemeal prevention programs will hardly bring about drastic changes in the AOD-using behavior of a client pool. Prevention evaluators also need to be able to classify numerous outcome measures into several system-relevant levels. Such a classification will help determine the breadth or scope of the program's success along individual, group, and systemic levels.

In discussing the methodological issues, we examine some of the methodologies that can be used to estimate the prevention treatment effect involving single-system evaluation designs, i.e., evaluation designs in which control groups are not available, as in the case of many community-based prevention programs involving Asian groups.

Finally, we highlight some of the major limitations of existing evaluation research involving Asian groups and present a series of recommendations that may advance the knowledge base of this particular area of inquiry.

Demographic/Socioeconomic Configuration of Asian Groups

The term *Asian/Pacific Islander* comprises more than 60 separate ethnic/racial groups and subgroups. These groups are very heterogeneous, differing in their histories experienced in the United States, languages and dialects, religions, cultures, immigration and generation histories experienced in the United States, socioeconomic statuses, places of birth (foreign versus United States), nationalities, and so on (Sue 1987).

In general, there are also vast differences in the degree to which these groups are acculturated and assimilated into the White Anglo-American mainstream (WAAM) culture (Kitano and Daniels 1988). At one extreme, there are unassimilated

Asians living in their own "cultural islands," such as Chinatown, Japanese town, or Korea town, and insulated from a sea of WAAM culture. They often have their own newspapers, radio and TV stations, churches, and shopping places where English is hardly spoken. At the other extreme are second- and third-plus generation Asians whose values and thought processes are indistinguishable from those of the WAAM culture.

Many Chinese and Japanese families have been in the United States for three generations or more. By and large, most Hawaiians, Samoans, Japanese, and Guamanians were also born in the United States. The vast majority of Vietnamese, Koreans, Asian Indians, and Filipinos in the United States, however, were born overseas. There is also a great deal of variation in the degree to which particular communities maintain their cohesiveness in terms of traditional customs, values, languages, and ethnic organizations (Austin et al. 1989). Thus, the tendency to group such diverse nationalities into a single Asian/Pacific Islander category tends to confuse the already lamentable state of research on this topic (Yu and Liu 1987). Accordingly, it does not make much sense to combine Asian Americans together other than to present the existing data as originally reported.

In terms of growth rate (not absolute population size) during the 1980s, the Asian/Pacific Island Americans were the fastest growing group of all the ethnic/racial groups identified by the U.S. Census Bureau. Between 1980 and 1988, that population increased by about 76 percent, compared with 36 percent among Hispanics. As of 1988, more than 6.5 million Asian Americans were living in the United States (see table 1), constituting 2.6 percent of the U.S. population. The U.S. population was expected to be just below 250 million by 1990, when it was also estimated that its Asian/Pacific Island-American population would be nearing 10 million, or just below 4 percent of the U.S. population. Of these 10 million Asian/Pacific Island Americans, 2 million, or 20 percent, were expected to be aged 5 through 17.

Regarding the educational attainment of Asian Americans compared with that of other ethnic groups in the United States, table 2 shows that, at 34.3 percent, the proportion of college-educated Asians is the largest, more than twice that for the U.S.

population as a whole (16.2 percent). The least educational attainment is found among American Indians (9.6 percent) and Asian/Pacific Island Americans (9.3 percent).

Table 1. Resident U.S. population by ethnicity (in millions), 1980–88

	1980	1985	1987	1988	Percent change 1980–88
White	194.7	202.8	205.8	207.4 (84.4%)	6.5
Black	26.7	28.9	29.7	30.2 (12.3%)	13.1
Asian/Pacific Islander	3.7	5.5	6.2	6.5 (2.6%)	75.7
American Indian and Alaskan	1.4	1.6	1.7	1.7 (0.7%)	21.4
Hispanic*	14.6	17.9	19.2	19.8 (8.1%)	35.6
U.S. population	226.5	238.7	243.4	245.8	8.5

Source: U.S. Bureau of the Census, *Statistical Abstract of the U.S. 1990* (Washington, D.C.: U.S. Govt. Print. Off., 1990), pp. 17, 39, 66, 164, 591, 641.

*Hispanic persons may be of any race. Thus, the sum of the ethnic groups constitutes more than the total U.S. population.

Table 2. Educational attainment of the U.S. total population, Asian Americans, Pacific Islanders, and American Indians aged 25 years or older: 1980

	4 or more years of high school	4 or more years of college	Rank order
U.S. population	66.5	16.2	7
Asian	75.3	34.3	4
Chinese	71.3	36.6	3
Filipino	74.2	37.0	2
Japanese	81.6	26.4	6
Asian Indian	80.1	51.9	1
Korean	78.1	33.7	5
Vietnamese	62.2	12.9	8
Pacific Islander	67.2	9.3	10
Hawaiian	68.4	9.6	9
Guamanian	67.9	8.2	11
Samoan	61.2	7.3	13
American Indian	55.8	7.7	12

According to the 1980 census, the median household income of Asian Americans ($23,095) is far above the national average ($19,917) (see table 3), whereas that of Asian/Pacific Island Americans ($17,984) is significantly below the national average. But despite the relatively high median household income of Asian Americans, a disproportionately higher segment of that population (10.3 percent) is living below poverty level, as defined by the U.S. Census Bureau, compared with the U.S. population as a whole (9.6 percent). The extent of poverty among Asian/Pacific Island Americans, on the other hand, is pervasive (16.1 percent). As may be expected, the proportion of families with married couples is somewhat higher among Asian Americans (85.1 percent) than among the Nation as a whole (82.8 percent), whereas the proportion among Asian/Pacific Island Americans (75.4 percent) is significantly lower. One may also

Table 3. Other socioeconomic characteristics of the U.S. total population, Asian Americans, Pacific Islanders, and American Indians: 1980

	Percent unemployed	Percent families with married couple	Medium income	Percent below poverty level
U.S. population	6.5 (7)*	82.8 (7)*	$19,917 (7)*	9.6 (10)*
Asian	4.6 (11)	85.1 (4)	23,095 (4)	10.3 (9)
Chinese	3.6 (12)	86.8 (2)	22,559 (5)	10.5 (8)
Filipino	4.8 (10)	83.6 (6)	23,687 (3)	6.2 (12)
Japanese	3.0 (13)	84.1 (5)	27,354 (1)	4.2 (13)
Asian Indian	5.8 (8)	91.0 (1)	24,993 (2)	7.4 (11)
Korean	5.7 (9)	86.0 (3)	20,459 (6)	13.1 (6)
Vietnamese	8.2 (3)	72.8 (12)	12,840 (13)	35.1 (1)
Pacific Islander	7.3 (4)	75.4 (10)	17,984 (10)	16.1 (4)
Hawaiian	7.0 (5)	73.2 (11)	19,196 (8)	14.3 (5)
Guamanian	6.8 (6)	79.6 (8)	18,218 (9)	11.6 (7)
Samoan	9.7 (2)	78.0 (9)	14,242 (11)	27.5 (2)
American Indian	13.0 (1)	71.9 (13)	13,678 (12)	23.7 (3)

*Values in parentheses refer to rank orders within columns note that the Asian household income often comes from multiple income sources rather than a single income source.

These demographic and socioeconomic parameters will be outdated and misrepresented by the year 2000. Recently, Southeast Asian refugees, Filipinos, and Koreans have been the fastest growing groups within the Asian-American population. According to the 1990 census (U.S. Bureau of the Census 1990), the Chinese (812,000), the Filipinos (782,000), and the Japanese (716,000) constituted the largest groups among all Asian/Pacific Island-American groups identified. By the year 2000, it is estimated that the Filipinos will be the largest group, followed by the Chinese, Vietnamese, Koreans, Indians, and Japanese. Thus, in the near future, the socioeconomic, demographic, and ethnic profiles of the Asian groups will change significantly. And such changes will undoubtedly bring about concomitant changes in patterns of AOD use in Asian communities in the United States.

Incidence and Prevalence: Alcohol and Other Drug Usage Patterns Among Asian Groups

Most information pertaining to AOD use among Asian Americans comes from isolated, ad hoc, nonrandom, snowball (referral) surveys or from local, community- or campus-based, or statewide surveys conducted either by individual researchers or State agencies. There are no prevalence data pertaining to the Asian population at the national level. The three major national surveys—the National Institute on Drug Abuse (NIDA) National Household Survey on Drug Abuse, the NIDA National Adolescent School Health Survey, and the High School Senior Survey—do not report results pertaining to the Asian group. Pre-1991 NIDA National Household Surveys excluded Alaska and Hawaii from the survey sample frames altogether. Moreover, most of the available survey data relate specifically to the use of alcohol.

On the basis of limited survey data generated by independent researchers and the States of Hawaii (Murakami 1989) and California (Skager et al. 1986, 1989), one may find a somewhat stable pattern of AOD use among Asian groups when compared with Whites. However, there are significant regional and ethnic differences found according to country of origin, socioeconomic status, place of birth, age, family structure, marital status, generation and immigration history, and so on.

Adults

The most conspicuous finding concerning AOD use among Asian Americans is that their use is less frequent than that of non-Asian individuals in general (Iiyama et al. 1976; Johnson et al. 1987; McLaughlin et al. 1987; Sue and Morishima 1982; Sue et al. 1979; Trimble et al. 1987; Tucker 1985). Most researchers consistently report that Asian groups have lower levels of alcohol use than other ethnic groups, with the exception of native Hawaiians, whose alcohol use appears to be comparable to that of Whites (Le Marchand et al. 1989).

Asians perhaps have the lowest alcohol prevalence rate of any major ethnic group in the United States, regardless of gender. Asian females consume alcohol far less often than White females. As is true with all other ethnic groups, Asian males are more likely than Asian females to drink and to drink heavily, and such a gender gap in drinking behavior may be larger among Asians than among any other major ethnic group in the United States.

Within Asian groups, only native Hawaiians drink alcohol at levels that are similar to those of Whites. According to surveys conducted by Hawaii's Department of Health (Hawaii Department of Health 1979; Murakami 1989), native Hawaiians have a higher alcohol prevalence rate than Filipinos, Japanese, or Chinese. However, there is some indication that alcohol use among Asian Americans is increasing. Japanese Americans generally rank after Whites and, in Hawaii, after native Hawaiians. In this context, it is interesting to note that Hawaiian residents of Chinese and Japanese ancestry have lower mean levels of alcohol use if they were born in Asia than if they were born in Hawaii (Johnson et al. 1987). On the other hand, Hawaiian residents of Caucasian ancestry have lower mean levels of alcohol use if they were born in Hawaii than if they were born on the mainland. These differences hold up even after controlling for the age of subjects (Johnson and Nagoshi 1990). The drinking patterns of Hawaiian residents are summarized in table 4. It may be added that the drinking patterns of Hawaiian residents of Caucasian ancestry who were born in Asia were not studied. Therefore, the magnitude of their drinking in relationship to that of other Hawaiian residents cannot be determined as yet.

Table 4. Rank order of alcohol use by Hawaiian residents: A summary table

	Place of birth		
Ancestry	**Asia**	**Hawaii**	**Mainland**
Asian	5*	4	2.5
Caucasian	?	2.5	1

*The values refer to rank orders, in which "1" is the highest prevalence rate.

Outside of Hawaii, although drinking patterns among different Asian groups vary considerably, it is generally believed that Japanese Americans drink the most, followed by Koreans and Chinese Americans (Chi et al. 1989). In terms of heavy drinking, however, Koreans seem to drink on a level similar to Japanese Americans. Heavy drinking, especially among the foreign-born Korean and Japanese Americans, is typical in business entertainment and after work in such drinking establishments as bars and nightclubs in New York, Chicago, Los Angeles, and Hawaii.

Youth

Among the young, traditional data indicate that AOD use is not as extensive within any one group of Asian youth as it is within the mainstream population or within most other ethnic groups. Most surveys indicate that AOD use by Asian youth is the lowest among all major ethnic groups found in the United States with the possible exception of African-American youth. According to a 1989 survey of students in grades 7 to 12 in Mecklenburg County, NC (table 5), the AOD use rate of Asian-American students is higher than that of African-American students but

Table 5. Percent of students, grades 7 to 12, who have used drugs, by ethnicity: Mecklenburg County, NC, May 1989

Drugs	American Indian (n=216)	African American (n=2,084)	Chicano Mexican American (n=43)	Puerto Rican Latin American (n=58)	Asian Oriental American (n=215)	White Caucasian (n=4,162)
Alcohol	58.4	44.8	64.1	56.9	39.2	*68.9
Cigarettes	48.5	20.6	*60.0	43.4	29.7	48.9
Marijuana	34.0	22.7	*48.7	20.8	14.9	27.9
Snuff	15.2	3.4	*27.5	11.3	7.4	15.1
ChewingTobacco	23.6	3.8	*35.0	13.2	9.9	16.6
Inhalants	13.2	2.1	*32.5	15.1	8.9	8.6
Amphetamines	8.9	1.6	*30.0	11.3	5.5	6.2
Clove Cigarettes	9.8	1.9	*32.5	13.2	7.4	9.6
Stimulants	13.8	2.2	*35.0	13.2	9.0	12.0
Nitrite	5.9	1.1	*20.5	9.4	5.4	2.9
Cocaine	10.8	3.1	*35.0	11.3	7.0	6.3
Tranquilizers	10.8	1.5	*25.0	11.3	5.4	5.3
Hallucinogens	11.8	1.3	*35.0	9.4	7.0	9.1
Methadone	8.8	1.2	*23.1	7.5	4.5	3.4
Opiates	6.4	0.9	*20.0	9.3	5.5	3.1
Barbiturates	9.3	1.4	*20.0	7.5	5.5	3.9
P.C.P.	8.3	1.2	*35.0	7.5	6.0	4.1
Ecstacy	7.4	1.0	*22.5	9.4	5.0	3.6
Steroids	8.3	2.4	*17.5	9.6	6.0	4.1
Needle Use	5.9	1.4	*23.1	5.7	6.5	3.1
Mean	16.0	6.0	*32.1	14.8	9.8	13.1

Note: The modal class pertaining to each drug type is preceded by an asterisk; mean is computed on the basis of 20 drug categories enumerated in the 1989 survey; n refers to subsample sizes pertaining to ethnic compositions.

lower than that of all other major ethnic groups (Kim and Shantzis 1989).

Similarly, a longitudinal survey of AOD use among students in Los Angeles in 1976, 1979, and 1980 reports that White students had the highest rates of use, followed by Hispanics, Asians, and African-Americans (Maddahian et al. 1986). In recent years, however, AOD use among Asian-American students has been increasing at an alarming rate. According to the survey of students in Mecklenburg County, NC, there was a significant increment of AOD use among Asian students during 1986–89 despite a general decline of student AOD use among all other ethnic groups identified during the same period (Kim and Shantzis

1989). In this study, the highest AOD use was found among Chicano/Mexican-American students, followed by Puerto Rican/Latin Americans, American Indians, White/Caucasians, Asian Americans, and, at the bottom, African Americans.

As far as infrequent alcohol use is concerned, Asian youths drink less than most major ethnic groups of young people in the United States. However, when it comes to heavy drinking (where *heavy* is defined as drinking at least once a week and drinking large amounts of alcohol on a typical occasion), Asian youths seem to assume one of the highest ranks, which may be quite comparable to that of White youths. Asian groups that appear to be at highest risk for developing AOD problems and those who actually abuse alcohol and other drugs have seldom been studied or have not been separately identified in previous research. The absence of study involving these youths seems to have contributed to the traditional underreporting of prevalence rates involving Asian-American youths.

Explaining Alcohol and Other Drug Abuse Among Asian Americans: Theories and Conjectures

As noted in the introduction, no valid evaluation research operates in a context-free environment and no evaluation task remains atheoretical. Atheoretical evaluation may be able to say something about the success or failure of a given prevention program on the surface without really knowing why the program succeeded or failed. Atheoretical evaluation research in this context is viewed as a sort of "empirical" rather than "scientific" approach. As such, it does not carry much of a conceptual "lead" toward the refinement of the program in the future. It is precisely for this reason that prevention evaluators have to place a heavy emphasis on understanding the theoretical underpinnings of a prevention project before embarking on an evaluation task. Without knowledge about the inner workings of the major factors that contribute to the AOD-using behavior of a particular Asian community, one can neither come up with an appropriate prevention program nor delineate a set of relevant dependent variables with which to assess the program with any degree of sensitivity, objectivity, and realism.

As we proceed to explain the AOD-using behavior of Asian Americans, we are faced with a multitude of theories, conjectures, hypotheses, correlates, and/or high-risk factors that are often cited in the AOD-related research involving Asian Americans (Messolonghites 1979) and are above and beyond those usually cited for Whites. Risk factors for Whites include low religiosity, low self-esteem, perception of incohesive family relationships, stress, negative peer pressure, excessive rebelliousness, lack of value attachment to school, poor student-teacher relationships, and negative social attitudes (Cooper 1983; Hawkins and Weise 1985; Hawkins et al. 1985; Jessor et al. 1980; Kandal 1982; Kaplan 1980; Kaplan et al. 1986; Kim 1981; Maddahian et al. 1988; Murray and Perry 1985; Polich et al. 1984). To these factors, which are cross-culturally shared, we must add a host of other variables pertinent to Asians: the content of their cultural values, traditions, attitudes, and beliefs; the degree to which they are socialized to the native culture; the degree to which they are acculturated to the dominant values of the host culture; the acculturation processes leading to cultural conflict such as the generation gap; family conflicts; role conflicts; alienation and identity conflicts; and many other situational high-risk factors dictated by immigration history and economic stress, especially among immigrant families.

In what follows, we present some of the major hypotheses generated by numerous researchers in the area of AOD use among Asian Americans. These hypotheses are grouped along three conceptual approaches: cultural content, cultural interaction, and general lifestyle changes that are assumed to be high-risk factors for AOD abuse. Although many of these approaches are based on alcohol studies, we hope they serve either as a template or a theoretical net with which to capture the major conceptual thrusts assumed by each community-based prevention project serving Asian communities.

Cultural Content Approach

This approach is based on the idea that cultural backgrounds and norms governing AOD-using styles in various cultures differ. For example, it is often noted that the WAAM culture values assertiveness, individual achievement, individualism, and spontaneity whereas the Chinese, Korean, and Japanese cultures value responsibility to others, interdependence, restraint, moderation, and group achievement. Alcohol use is thus presumed to be more in keeping with WAAM culture than with Eastern traditions (Kua 1987; Sue 1987). As noted by Austin and colleagues (1989), Asian drinking also is thought to be more social than solitary, occurs in prescribed settings, is usually accompanied by eating, is used more to enhance social interaction than to provide an escape, and occurs within the range considered moderate. Moreover, Asian women are expected to drink little or no alcohol.

It is obviously true that descriptions of cultural backgrounds and drinking styles in various Asian groups differ in detail. This may account for some of the variations in the AOD use patterns of numerous Asian groups, as discussed in the previous section. On the other hand, it is also true that the drinking attitudes and customs of the various Asian cultures are similar in their encouragement of moderation and that none of these cultures advocates or encourages excessive alcohol use. This may account for a significantly lower prevalence rate of alcohol use among Asian Americans when compared with Whites. Likewise, many studies, perhaps starting with Ullman (1958), argue that uncertainties and mixed messages in the culture regarding alcohol use produce ambivalent feelings within individuals about drinking and that these feelings increase the probability of problems once an individual begins to drink (Peele 1987; Room 1976).

Nearly all cultures share some values, and there are more commonly shared values than there are conflicting ones among the various major cultures. More important, perhaps, is that—within these common and conflicting values—there are differences in the degree to which different cultures emphasize various cultural contents. For example, Asian Americans generally seem to place a higher degree of emphasis on educational values than do some other ethnic groups in the United States. As many Asian parents hope for fulfillment in their own lives through the success of their children, Japanese, Korean, and Chinese parents instill in their children from very early on the idea that parental acceptance is contingent on the child's educational performance. Low performance by the child can elicit not only parental disapproval and criticism, but also disappointment and sometimes shame among the relatives. On the other hand, high educational performance by other Asians is often given prominence and recognition in the community. This may partially explain why many Asian children do well in school.

With overtly critical parents, however, Asian youth—especially those whose educational performance falls short of parental expectations—not only get involved with drugs but also want to move away from their cultural identity. Some Asian-American youth are under great pressure to succeed because of the "model minority" stereotype and the high expectation for achievement imposed upon them by their parents. Furthermore, many Asian parents, especially among the Korean, Japanese, Chinese, and Vietnamese, believe that the only viable means of survival in the larger mainstream society is through educational attainment and excellence. Asian-American youths who find a gap between what is expected of them and what they have actually achieved experience a high degree of emotional stress in their fear of failure, which they may try to relieve through use of alcohol and other drugs (Sekiya 1989).

By far, the cultural content approach to Asian-American drinking is the one most widely shared. However, it has its limitations in that it fails to account for vast differences in the drinking behavior of many Asian subgroups (see the previous section). Accordingly, any attempt to explain drinking solely on the basis of cultural content is thought to be ill-advised. In our examination of the etiology of AOD abuse among Asian groups, physiological factors such as the "flushing reaction" are excluded from our discussion because such a factor cannot be altered using community-based prevention models. (For recent reviews on this topic, see Chan 1986; Clark 1988; and Stoil 1987/88.)

Cultural Interaction Approaches

Cultural interaction approaches attempt to explain Asian-American AOD-using behavior based on the different processes through which individuals in an ethnic/racial culture adapt to the larger WAAM culture. The three leading approaches are the acculturation theory, the orthogonal cultural identification theory (OCI), and the cultural conflict approaches.

Acculturation Theory

The acculturation theory is founded on the idea that there is an ethnic/racial culture that exists within a larger, dominant WAAM culture. Within that dominant WAAM culture, cultural transition occurs along a single continuum, whereby an increasing identification with the WAAM culture is associated with a diminishing identification with the native culture. Accordingly, the acculturation theory attempts to explain the AOD-using behavior of Asian Americans in terms of their associated cultural transition, which is assumed to be unidirectional—from an ethnic/racial culture to the WAAM culture. Much of this theory has been based on the alcohol-using behavior of Asian Americans.

According to this theory, Asians who are recent immigrants should drink in a manner similar to the drinking pattern in their home country. As they become more acculturated into the WAAM culture, however, their alcohol-using behavior should become more like that of White Americans. Following this line of reasoning, the drinking patterns of the first, second, third generation, and so on should progressively resemble that of White Americans. This is so because the WAAM culture contains more lenient and positive attitudes toward alcohol consumption and possible abuse (Chi et al. 1989; Kitano et al. 1985; Sue et al. 1979; Yuen and Johnson 1986).

However, others have challenged the acculturation theory by noting that the degree of acculturation is not a significant predictor of drinking among Asian-American college students (Akutsu et al. 1989). These researchers have operationalized the concept of acculturation in terms of the Contrasting Values Survey (Connor 1977), which is based on an absolute benchmark definition of acculturation (i.e., Eastern cultural values versus Western cultural values) rather than on a relativistic (moving target) definition of acculturation (i.e., the ever-changing cultural values of a particular group within the WAAM culture). Research by Kitano and colleagues (1988) and by Kitano and Chi (1989) also refutes the explanatory capability of the acculturation theory by noting numerous other mediating variables that lie in between the logical process of acculturation itself and actual drinking behavior: community and family cohesion, receptivity by the dominant community, life experience, and so on.

One study reports assimilation (especially acculturation with marital or mixed parentage) into the WAAM culture as having an important incremental influence on the level of alcohol use; it found that individuals of mixed Asian-Caucasian ancestry had a mean alcohol consumption level very similar to that of Caucasians and considerably higher than that of Asians (Wilson et al. 1978). This study, which was based in Hawaii, also controlled for socioeconomic variables (i.e., social class and gender).

Orthogonal Cultural Identification Theory

The main theme of the Orthogonal Cultural Identification (OCI) theory (Oetting and Beauvais 1990) is that a person's cultural identification does not rest along a single continuum. Rather, there are numerous dimensions of cultural identification, and these dimensions or identifications are independent of each other. Thus, increasing identification with one culture does not require decreasing identification with another. Specifically, as we apply this to the Asian cultural content, one's identification with an Asian culture does not entail a loss or decreasing level of identification with the WAAM culture.

According to Oetting and Beauvais (1990), higher cultural identification is related to positive psychosocial characteristics. Thus, strongly bicultural youth have the highest self-esteem and the strongest socialization links, whereas the anomic youth (having a low level of identification with either culture, native and host) is expected to show the lowest self-esteem and the weakest links to family and school, two major socialization systems. Again, as applied to Asian-American youth, Asian and WAAM cultural identifications are expected to coexist and function as essentially equivalent sources of personal/social strength. Therefore, youths with strong bicultural identification are expected to use alcohol and other drugs the least because they are simply more adaptable than those with weaker bicultural identification, the extreme being anomie. The implication for prevention, according to the OCI theory, is to present information and teach these youth the cultural norms of the Asian culture or of cultures they want to know or associate with. Such is the case of many ethnic/racial-oriented prevention programs whose strategy is based on the cultural enrichment model.

Cultural Conflict Approaches

Generation Gap Leading to Family Conflict

For early immigrants and first-plus generations, the problems are not usually those of language or of basic survival needs but are those related to conflict between their parents' culture and the dominant WAAM culture. Specifically, Asian youths need to cope with the demands of the dominant culture to be more "Americanized," on the one hand, and with the expectations and occasional demands of their parents to be more like they are, on the other. Although the processes and effects of acculturation are complex, it is safe to state that young people generally learn and adapt to the new environment faster than their parents. In such a context, the kind of parenting skills used by Asian parents may often prove to be ineffective or inappropriate in the eyes of youth. This gap in acculturation between parents and offspring (i.e., a generation gap) has the likely potential to contribute to identity crises and/or to some family instability. The latter leads to the child's perception of incohesive family relationships. This perception is typified by such statements as, "My parents and I don't understand each other," "My parents don't know what they are talking about," or "My parents and I can't communicate with each other." To these statements, parents typically respond by saying, "This is *our way*" or "This is what *we* do in *our culture*."

Youth: Peer Group Pressure

Due to cultural conflicts, many Asian youths separate themselves from their families and create their own support networks with their peers. Many second- and third-generation Asian-American youths do not want to be identified as Asian because of the association with newly arrived immigrants and refugees. Many American-born youths carry negative views of newcomers, in part instilled by their elders; others feel threatened by the rapid transformation and new "foreignness" of their neighborhoods. Sensing these reactions, the immigrant youth may further isolate themselves, ratcheting up the level of their mistrust. For either group, the tumultuous new environment does not leave much room for an appreciative understanding of each other.

New immigrant youth also lose respect for their parents and begin to identify more with peer clusters. An extreme example of such peer involvement is the Asian youth gangs, whose delinquent behaviors are on the rise in some major metropolitan areas of the country. The mainstream media are beginning to pay more attention to these gangs and their associated crimes of extortion, violence, auto theft, gambling, drug use, and drug trafficking. In some communities, Asian youths have dropped out of school; been forced out of their homes; are living on the streets; and are linked to auto theft, drug use, and gang wars, challenging rival gangs and committing acts of violence that involve firearms.

Asian Women: Role Conflict

As already noted, Asian women drink far less than Caucasian women. However, the rate of cigarette, alcohol, and tranquilizer abuse among Asian women does seem to be increasing. One factor that cuts across Asian subcultural lines is the rapidly changing attitudes on the part of Asian women about their traditional roles and functions. Traditionally, Asian women are characterized as demure, docile, passive, and humble people who practice reluctance in self-expression. Their self-worth is measured through the "good" husband they marry; their femininity is seen in the accommodating role they assume with family members while being subservient to their husband.

However, this traditional characterization of accommodating Asian women is being eroded and challenged by the WAAM culture, which places a high value on individualism, independence, and self-worth (Arakaki and Antonis 1978; Namkung 1972), and by the desire of Asian women to develop their own uniqueness (Arakaki and Antonis 1978). Their traditional role is also being challenged by economic factors, which force both the husband and the wife to work while the wife is expected to assume the added responsibilities of attending to household chores and cooking for the family. Many Asian husbands are trained to consider such household activities to be far more demeaning than husbands in the WAAM culture consider them to be.

Alienation and Identity Conflict

Due to their small size, lack of political power, physical appearance, skin color, and passivity, as well as to the perceptions of them held by the majority population, many Asian youths and adults do not feel connected to or part of the mainstream society. Particularly, many Asian Americans at the lower socioeconomic levels face the threat of discrimination, racism, and even violence in their daily lives. One is reminded of the Stockton school yard massacre of Southeast Asian children by a mentally ill gunman who hated Asians; of cross burning on the lawns of Filipino families in Daly City; and of Korean grocers challenged by African Americans in New York (Goodstein 1990). These are vivid examples of the threat of prejudice and racism. As a result of a multitude of social forces over which they do not have much control, Asian Americans feel alienated and experience identity conflict. These feelings are often accompanied by loneliness, no sense of belonging, helplessness, powerlessness, low self-esteem, and, for some, loss of a sense of the meaning of life. All of these are frequently cited as contributing factors to AOD abuse across cultures.

High-Risk Factors

Numerous high-risk factors are common to both Asian and non-Asian youth. As previously mentioned, experts in the field of prevention have cited low religiosity, low self-esteem, boredom, school absenteeism, perception of incohesive family relationships, low self-confidence, emotional stress, negative peer pressure, sensation seeking, excessive rebelliousness, lack of value attachment to school, poor student-teacher relationships, negative social attitudes, attitudes favorable to AOD use, peer AOD use, and so on. (For a more detailed discussion of the topic, see Jones and Battjes 1985; Kim 1981; Kim and Newman 1982.) Asian youths and adults, however, experience added personal, family, and social problems by virtue of their immigration status, economic stress, racism, and discrimination.

Immigrants: Feeling of Personal Failure

For many adult immigrants, their greatest source of stress lies in the overwhelming priority placed on basic survival needs. This leaves little room for the emotional support, attention, and time needed to discipline their children and build social skills. Consequently, these immigrants experience defeats in personal competency shortly after their settlement. The attention given to basic survival needs and adjustment demands continues to erode individual life and family life just at the time when such strengths are needed the most. For example, educated immigrants are often underemployed so they can attend to the immediate basic survival tasks, i.e., a drastic difference in the social status of the jobs held in the country of origin and the host country.

Immigrants: Role Reversal

In families in which the parents do not speak English, children who do may be forced to accept certain adult responsibilities—e.g., spokesperson for the family. This is a clear role reversal for the father in his traditional role as the source of authority in the family. Youths may lose respect for their elders because the elders are unable to assume their traditional authoritative roles or provide financial support for the family. Discrepancy between one's capability and what one does for a living, or between the "respectable" job one held in the country of origin and what one's child may see as the "demeaning" job now held in the host country can mean a loss of control over the child. The impact of such discrepancies on the family can bring about depression, alienation, anomie, and family conflicts, as well as the abuse of alcohol and other drugs.

Immigrants: Economic Stress

Many recently arrived Asian immigrant families are unable to support themselves financially due to poor English proficiency, a lack of job skills, and relatively large family sizes. Southeast Asian refugees are three to four times more likely to be on public assistance than African Americans or Hispanic Americans. Although Filipino Americans show low unemployment, they are often stuck in nonprofessional, service-oriented job markets that are subject to poor pay, frequent layoffs, lack of job advancement opportunities, and differentiated work schedules. Compared with other Asian immigrants, Korean Americans are most likely to be self-employed. This means long hours and hard work with limited financial return.

Moreover, many recently arrived Asian immigrant families are supporting not only their immediate family but also their extended family members in their native country. These mutual assistance "family obligations" place additional economic pressures on the family; these pressures, in turn, limit the parents' involvement in their children's lives. Because of their parents' long working hours and low wages, many children are unsupervised and live in marginal conditions.

Economic stress can be transmitted to youth in many ways. Asian youth are often obligated to work in the family business without compensation and have limited social lives. Furthermore, immigrant youth may be ostracized by peers for not being able to afford to dress in trendy fashions, and not having spending money to participate in "normal" youth activities. Particularly for the recently arrived refugee and immigrant population, the following have been cited frequently as common problems: low English literacy, or illiteracy; a learning style incompatible with the Western teaching style; a lack of experience in the learning situation; the absence of health insurance for many self-employed individuals who operate small "mom and pop" stores; very little knowledge of the cultural norms of the majority population; and transportation difficulties, such as no funds to own a car or a lack of the appropriate knowledge about driving a car or about traveling by bus or by other means. Some researchers have therefore placed refugees and recent immigrants at a higher risk for AOD abuse than other Asian groups as a result of these economic stresses (Zane and Sasao 1990).

Prevention Strategies/Models Involving Asian-American Communities

From both a logical and an ideal viewpoint, prevention strategies (or models) should have been developed after a theory on the etiology of AOD abuse among Asian groups had been advanced. In the natural evolution and development of prevention strategies for Asian Americans, however, there has been a lack of communication between the theorists on the one hand and the program developers/practitioners on the other. In the absence of such dialogue, and given the fact that Asian Americans tend to underuse AOD abuse programs, many community-based prevention strategies for Asian communities have been devised based on conjectures or intuitions, and sometimes in response to the specific needs of Asian communities and their youth. What is particularly important to note is that many of these strategies have been developed independent of any theoretical assumptions about involving Asian Americans and their use of alcohol and other drugs. Some have even been implemented without any real knowledge about whether they actually help deter AOD-using behavior in Asian-American communities. Thus, whereas a prevention strategy advanced by theorists may be the cultural enrichment model (see below), a prevention strategy advanced by prevention practitioners may be to emphasize the personal styles of field workers and their level of commitment rather than to choose a particular theoretical persuasion.

Since the early 1970s, a few community-based prevention programs have come into being in Los Angeles, New York, San Francisco, and Hawaii. All have been based on different theoretical assumptions, conjectures, and client needs, as reflected in the various common and unique characteristics of their client base. Essentially, these foundations have supported the following six prevention models: (1) the case management model, (2) the family-oriented model, (3) the information deficit model, (4) the empowerment model, (5) the cultural enrichment model, and (6) the mutual support model.

In what follows, we try to describe these prevention models and, whenever possible, establish a conceptual link between them and the theories described in the previous section. No claim is made that these prevention models are mutually exclusive or that together they constitute a totality of all the prevention strategies available to date. We hope that others may add on to or branch out from the list assembled here.

Case Management Model: Basic Needs Approach

The case management model is based on the assumption that no prevention or intervention services can be successful unless they address the basic needs of the ethnic/racial clients, especially those who are recent refugees and immigrants (Cross et al. 1989). Many ethnic/racial children, youth, and families expect formal helpers to be able to deal with a variety of problems. Their needs, which are both economic and emotional, usually range from the mundane to the specialized and include such things as help with applying for a driver's license, using public transportation, opening a checking account, job training, access to health care, and so on.

Because of both the depth and the breadth of the problems besetting many Asians, the service philosophy based on case management with networking has become the essential part of the prevention services rendered to them. Here, networking involves referring clients not only to formal social service agencies, but also to other informal support networks such as churches, schools, associations, self-help groups, business and industry, and so on. As one of the mainstay prevention strategies for many Asian refugees and immigrants, the case management model is founded, either implicitly or explicitly, on the high-risk factor emanating from the economic stresses as well as the cultural conflict theories enumerated in the previous section.

Case management is more than a simple referral service. To establish a rapport with the family, one needs to use the native speaker as the facilitator or case manager. This role may include speaking for and with both child and parent to representatives from other organizations, such as schools, mental health clinics, juvenile courts, and recreational programs. The goal is to persuade other people to join a collaborative effort to design, develop, and sustain a system of care for the child and the family. Case management, therefore, is seen as an opportunity to teach self-advocacy, to assess the strengths of the client, and to learn about the client's natural support network, such as informal groups of people, friends, relatives, neighbors, ministers, and so on. And for community-based prevention programs that use this model, the evaluation system must be ready to gauge the degree to which the programs are ready to accommodate these and other basic needs that mainstream service agencies may take for granted. The prevention programs targeted for this type of refugee/immigrant population must provide services that are suited to their clients. The evaluation process needs to reflect on these services as their concomitant dependent variables.

Family-Oriented Strategy

Most Asian prevention agencies consider the family-oriented strategy to be one of the most important. This strategy is based on the traditional Asian cultural content, which puts the family's needs above those of the individual. Many researchers have emphasized Asian family cohesiveness and stability (as exemplified by their lower divorce rate) as a protective force and one of the major deterrents against youthful problem behaviors such as AOD use and other antisocial and self-defeating behaviors. Traditionally, the Asian family unit is the pillar of strength and stability for all its members, and it plays a critical role in the ongoing development and support of the child even into adulthood. Furthermore, familial decisionmaking and control usually include extended family members, such as grandparents and other significant relatives. Children are taught to obey elders and to put the family's needs above their own.

Similarly, Asian families and extended kinship networks have often been cited as an important protective factor against many mental health problems (Hsu 1973). And Johnson and Nagoshi (1990) have suggested that the existence of extended families among Asian Americans is a factor in reducing alcohol consumption (Johnson and Nagoshi 1990).

Similarly, we are aware that AOD abuse among Asian Americans is underreported due to the Asian family's denial of the problem and extreme resistance to outside interventions, especially from WAAM social service agencies. Reflecting on this cultural content, the family-oriented approach emphasizes the importance of including family members in all its prevention, intervention, and treatment programs.

Information Deficit Model

The essence of this model is to treat the limited skills and competencies of Asian groups—as well as their adjustment problems, both social and familial—as a skills and information deficit rather than as a cultural or ethnic weakness. Under this model, both the prevention agency and the prevention facilitator present themselves as sources of information, providing an opportunity for the immigrants/refugees to learn. The facilitator is expected to provide helpful services and not to assume the role of a "fixer," who will enter their lives to change them or fix them up. This model emphasizes Asian respect for education while downplaying the notion of an "opportunity to change."

With regard to drug specific information, many American-born Asians tend to subscribe to a more inclusive definition of *drug,* which includes alcohol and cigarettes. Foreign-born Asians on the other hand are more likely to subscribe to a more restricted definition, which excludes alcohol and cigarettes. Zane and Sasao (1990) found similar results involving Japanese Americans. This may have important prevention implications for Asian Americans whose parents were not born in this country. Accordingly, prevention strategies have been devised to increase knowledge about drugs. This includes providing education on alcoholism and other drug abuse to lessen the stigma among Asian Americans that is attached to seeking professional help.

Empowerment Model

This model was originally developed for African-American communities during the late 1960s and early 1970s. It is in part based on the alienation and hopelessness syndrome as a potential cause of AOD abuse. The empowerment model emphasizes a movement away from "hand-me-downs" and "handouts" (the privileged giving to the deprived) to an indigenous grassroots movement toward self-determination and self-sufficiency in a setting of cultural pluralism (Asian American Community Mental Health Training Center 1981; Blum 1979). Such an empowerment process is built around the notion of strengthening the members of the indigenous group chosen as the target population.

Operationally, one criterion for measuring program success can be based on the degree to which the indigenous actors participate in the empowerment process. For those community-based prevention programs based on this model, potential indicators of program success may include both the number of people in the target population serving in decisionmaking positions in that ethnic/racial group's governing body, and the number of community-initiated projects launched, such as self-help groups, forums, supportive service organizations, task forces, special interest groups, fraternal or school associations, sporting activities, and so forth.

Cultural Enrichment Model

During the discussion of the cultural interaction approaches in the previous section, we noted that all immigrants go through the process of adapting to the dominant WAAM cultural values. During this culturally interactive process, however, some immigrants lose their Asian cultural identity (the acculturation theory) while others maintain it (as implied through the OCI theory). Many community-based prevention programs are built around the notion that AOD use is less frequent among individuals with either bicultural or monocultural identification than it is among those who are anomic. Programs based on the cultural enrichment model are related, either implicitly or explicitly, to the major theoretical proposition advanced by the OCI theory that a greater identification with either the ethnic/racial or the majority culture is a source of both personal and social strength.

A major consideration in evaluating the success or failure of a prevention project based on this model should be its influence in shaping and enhancing subculturally valued cultural characteristics within the project group (e.g., respect for the elderly, the practice of culturally unique ceremonial activities). Also, as the cultural norms for what is and is not acceptable drinking behavior within Asian cultures are fairly clear, program evaluation should draw attention to these norms in determining the appropriate level of prevention for program success.

Mutual Support Model

Much of this model uses the high-risk approaches enumerated earlier. The model is based on the notion of Asians, who are in the process of adapting to a larger, pluralistic society, sharing common experiences in and solutions to such issues as life adjustment, cultural conflict, family conflict, child rearing, and so on. In recent years, many prevention and treatment professionals have realized the value of getting their clients together with those who share similar problems. Through mutual help and support, participants in these group meetings discover additional or alternative ways of coping with both normal and unusual crises in their lives. By talking with others about their difficulties and their efforts to overcome them, participants find both comfort and enlightment (Silverman 1980). It is also believed that sharing similar kinds of problems in a setting that is mutually supportive instills a sense of normalcy and stability rather than prompting crisis-oriented, hasty decisions or panic reactions that may be disruptive to oneself or one's family.

Cultural Nuances That Affect the Outcome of Implemented Prevention Strategies/Models

Different cultures have different nuances. Even the use of the same words, gestures, symbols, and behavior connote different meanings, leaving plenty of room for uncertainty, misconception, and misinterpretation. Many times, we tend to argue that "we are all alike when it comes right down to it." But, in fact, we both are and are not alike at the same time.

Listed below are some of the social interaction skills and techniques that reflect cultural differences and thus may have implications for the outcome of intervention and evaluation processes. Each of these behaviors could easily be interpreted as weakness, resistance, or family dysfunction if the program evaluator lacks a cultural awareness of the Asian clients served. Adaptation to the usual assessment process involves learning what is "normal" in the context of the client's culture.

1. In many Asian groups, children are taught to express their remorse about a misdeed by not looking at the adult who is correcting them. In some Asian cultures, the very act of looking straight into the eyes in such situations is equated with disrespect. In fact, direct eye contact is often avoided in a setting of formal conversation, even among adults.
2. A limp handshake by a person from some Asian subcultures may well mean humility and respect. Yet WAAM male culture often judges a person's character by the firmness of the hand grip (Cross et al. 1989).
3. In many Asian cultures, silent patience is thought to be a virtue in life. In organizational settings, any formal or informal complaint directed toward the higher level of that organization is therefore held in check and delayed as long as possible or until that time when the Asian employee thinks the problem "has gone too far." The very nature of silent patience also inhibits open communication, especially regarding grievances. This often results in the unspoken decision to do things based on one's own soul-searching and self-awareness. If, in fact, an employee registers a formal

complaint with the management of the employing organization, the conflict resolution is not likely to be a routine process. The employee's behavior may well involve highly emotional feelings that have been bottled up to an almost unbearable level. This may cause the employee to behave in a way that could easily be interpreted as "unacceptable" by the WAAM culture and that could leave no room for working toward a satisfactory resolution acceptable to both management and employee.

4. Any demonstration of one's importance in social interactions or any associated symbols or connotations of "I" or of self-assertion are thought by some Asian cultures to be signs of immaturity and a lack of social skills. Especially among Koreans, it is actually social etiquette to belittle oneself as well as one's family members.
5. The Korean and Japanese languages have a fundamentally different style in using the responses of "yes" and "no." For example, let us assume that Charlie missed school yesterday. If one asks Charlie in English, "You didn't go to school yesterday, did you?" Charlie would correctly answer, "no." In English, the answer is based on the self-assessment of the person who is being questioned as to what he or she did or did not do, irrespective of the questioner's particular assumption. In both Korean and Japanese, however, the correct response would be "yes" because Charlie would be confirming what the questioner assumes. In other words, the Korean and Japanese languages are based on the cognitive level of the person asking the question as interpreted by the listener. In this case, the questioner assumes correctly that Charlie did not go to school, so Charlie's answer is "yes." If, on the other hand, someone asks Charlie in Korean or Japanese, "You went to school yesterday, didn't you?" the correct answer would be "no" because the person asking the question assumes incorrectly. In Chinese, the choice of "yes" or "no" is identical to that in English.
6. Some Asian groups express politeness through maintaining an agreeable demeanor in a helping encounter. The professional or social worker may mistake this for acceptance and

rapport when the Asian client actually has little or no understanding of what the worker expects (Ho 1976).

7. Failure to address the male first in some cases will seriously restrict what can be accomplished. In traditional Asian families, failure to engage elders—especially elder males as the primary access to the rest of the family—will inhibit the effectiveness of the professional in cross-cultural intervention processes (Ho 1976).
8. To many Asian groups, physical contact (e.g., a handshake, hugging, or facial contact in greetings) between those of the opposite gender is often interpreted as a sexual advance or overture.
9. Many Asian groups, especially those who have been subjected to a history of slavery and political oppression, show little emotion (e.g., do not smile or laugh so much) and are not likely to express their own feelings and desires. For example, strangers in general neither exchange smiles nor greet one another, not even in close encounters. But this does not mean they are unfriendly or disrespectful to one another.
10. Some Asian groups, especially recent immigrants, find it somewhat uncomfortable to give and receive compliments such as "You look nice today" or "I love your hair style" or "Thank you very much for helping me," or to respond by saying "Thank you" or "You are welcome." To some, acceptance of such a compliment with such a typical WAAM response is awkward, although not unacceptable, because they interpret it as a sort of acquiescence to self-affirmation. Their preferred response is instead a mild denial such as, "Oh, it's a cheap old dress I bought a long time ago." Or it may be an act of avoidance, such as ignoring the compliment with silence or an awkward facial expression and shying away from that particular encounter. Or it may be a slight gesture of denial with the head turning away from the complimenter, especially in response to a compliment such as "You look nice today." These social interactive behaviors, it must be noted, do not signify "unappreciation"; rather, this kind of communication style is embedded in the traditional cultural mold, which deemphasizes oneself and

individualism while emphasizing self-humility in social interactions.

11. In most Asian cultures, stretching one's legs on a table, even in informal settings, is not only thought to be impolite and unacceptable, but is also generally interpreted as highly disrespectful to others. In the mainstream culture, such an act may similarly be interpreted as impolite and unacceptable, but not to the same degree of intensity felt by Asian Americans.
12. Bringing children to formal and informal social engagements is largely considered acceptable among many Asian groups.
13. Arabic number four is associated with the symbol of death in Korean, Japanese, and Chinese cultures.
14. Despite social, moral, and legal sanctions against it, wife abuse in Korea and Japan is far more common than is estimated in the WAAM culture. Such an act, therefore, should not be interpreted as "abnormal" to the same degree that it is within the WAAM culture.
15. In some Asian communities, as in some Latino and American-Indian groups, the concept of time is diffused, lax, and less formal. Accordingly, a formal appointment may be a foreign concept. Unless such a scheduled appointment is followed through with a personal phone call, the appointment may not be kept. Among indigenous Asian groups, work hours, spiritual practices, or family obligations may conflict with scheduled appointments.
16. Many Asian groups strongly believe that parents have a right as well as a responsibility to spank or physically punish their child when that child misbehaves. Such a practice is far more common in Asian groups than in the WAAM culture.
17. For many Asians, the exchange of small gifts is ingrained in their social interaction. It plays a very important social function, which may be described as a sort of social lubrication; that is, it "makes things go smoothly." Accordingly, it is very helpful to share materially helpful household items (not money) when making home visits.

These are some major social behaviors and interaction skills that may directly affect the outcome of any implemented intervention and evaluation processes. These cultural specificities are important guidelines during the data-gathering phase, especially during the interviewing process.

It must be noted that all cultural variables are in flux and that many of the Asian values and behaviors listed above are going through gradual change, especially among the young. Accordingly, the above statements should not be interpreted literally in every case. There is always the danger that any one of them may impute stereotypical attributes to Asian Americans.

Analyzing the Cultural Competence of Prevention Agencies

Classifying Prevention Agencies Based on Organizational Structure

In the absence of a general theory or a set of minitheories that explain AOD-using behavior within a particular Asian group, and given the fact that Asian Americans tend to underuse AOD programs, prevention programs have been developed that are responsive to the specific daily needs of Asian communities and their youth. In particular, numerous mainstream and ethnic/racial organizations have devised various strategies to make their service facilities more accessible, whether or not they have culturally competent staff or bicultural programs or orientations. It is in this context that program evaluators need to be sensitive about the organizational structures and their characteristics to determine the degree to which those agencies are ready to provide culturally relevant services to Asian-American communities.

A survey of prevention service agencies serving Asian clients reveals the following types of service agencies:

1. Mainstream agencies with neither a bilingual staff nor a bicultural program providing prevention outreach services to Asian clients.
2. Mainstream agencies with a bilingual staff but not a bicultural program providing prevention outreach services to Asian clients.

3. Mainstream agencies with both a bilingual staff and a bicultural program outside the Asian community providing prevention outreach services to Asian clients.
4. Mainstream agencies with a bilingual staff providing bilingual/bicultural services within Asian communities.
5. Asian community agencies providing prevention outreach services to all Asian consumers.
6. Asian agencies providing bilingual/bicultural services to Asian groups within the Asian community. In these cases, a specific Asian cultural group provides prevention services to its own cultural group using its own native/bilingual staff. In the natural evolution of prevention organizations serving Asian communities, this would be the ideal type of organizational structure.

A Cultural Competency Continuum: Gradation in Cultural Competence

Instead of looking at the organizational structure to determine the cultural competence of a prevention organization, Cross et al. (1989) suggest a gradation of cultural competence exhibited by each organization. Cultural competence can be thought of as a single continuum, ranging from cultural destructiveness (CD) at one end to cultural proficiency (CP) at the other (see fig. 6). In between are cultural incapacity (CI), cultural blindness (CB), cultural openness (CO), and cultural competence (CC).

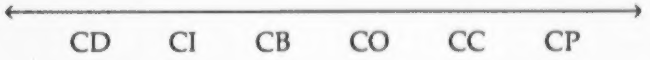

Figure 6. Cultural Competency Continuum

A brief description of each anchor point on the continuum is presented below with minor modification to the original delineation offered by Cross et al. (1989):

CD: *Cultural destructiveness* represents a set of attitudes, practices, and/or policies that is designed to promote the superiority of the dominant culture and that purposefully attempts to eradicate the "lesser" or "inferior" culture because it is viewed as "different" or "distasteful."

CI: *Cultural incapacity* refers to a set of attitudes, practices, and/or policies that, while not explicitly promoting the superiority of the dominant culture, adheres, either explicitly or implicitly, to the traditional idea of "separate but equal" treatment. This naturally breeds segregation and discrimination and eventually institutionalizes such practices. Organizations thus predisposed are therefore incapable of helping ethnic/racial clients or communities.

CB: *Cultural blindness* refers to a set of attitudes, practices, and/or policies that adheres to the traditional philosophy of being unbiased. Under this paradigm, culture and people are basically all alike, and what works with one culture should therefore work as well with another. The eventual consequence of this belief is to "make services so ethnocentric as to render them virtually useless to all but the most assimilated people of color" (Cross et al. 1989).

CO: On the way toward becoming a culturally competent agency, the *culturally open* organization adheres to attitudes, practices, and/or policies that are geared toward the learning and receptivity of new ideas and solutions to improve services rendered to one's particular target group. The initiating processes of cultural diversity may begin with the hiring practices of one's staff, staff training in cultural sensitivity, minority representations in the board membership, and so on.

CC: *Culturally competent* agencies are characterized by a set of attitudes, practices, and/or polices that respects, rather than merely shows receptivity to, different cultures and people. In the process of enhancing their quality of services, such agencies actively seek advice and consultation from ethnic/racial communities and actively incorporate such practices into the organization with a sense of commitment.

CP: *Cultural proficiency* is characterized by a set of attitudes, practices, and/or policies that holds cultural differences and diversity in the highest esteem. Culturally proficient organizations hold a "proactive" posture regarding cultural differences; their aim is to improve the existing quality of services through active research into cultural issues in preventive and therapeutic approaches that affect the service outcome. They not only engage in the dissemination of such research findings, but also promote improved cultural relations among diverse groups in society through public education and awareness campaigns.

Assessing Cultural Competence: Cultural Competency Scales

Alternatively, evaluators may be able to determine the relative degree of cultural competence assumed by a prevention agency by asking a series of questions pertaining to past and present performances. Given a sufficient number of questions asked, this would produce an interval type scale, which could be used to measure the cultural competence of the organization under investigation. Such a scale may prove useful for a comparative analysis of the cultural competency of prevention agencies.

To take another example, the minority service success (MSS) rate can be devised by computing the ratio of targeted Asian clients actually served by the prevention agency during a specific period (e.g., the last fiscal year) to those who could have been served during the same period. The latter variable may be computed on the basis of total number of clients served as a proportion of the entire population served by a reference (i.e., similar or equivalent) agency or, in the absence of such a reference agency, by agencies serving the mainstream population.

Formally, the MSS rate can be computed using the following formula:

$$EX = NT \times TY / N,$$
$$MSS = AX / EX \times 100$$

where

EX = Expected number of Asian clients who could have been served during the same period.
NT = Total size of targeted ethnic/racial population within a larger community.
TY = Total number of clients served by Y reference agency during a particular period.
N = Total population size of a larger community in which the target population resides.
MSS = Index score of minority service success rate.
AX = Actual number of Asian clients served by X prevention agency during a particular period.

For example, let us assume that the population size of a particular community (N) is 3,000, which includes 600 individuals (or 20 percent) who belong to a particular ethnic/racial population group (NT). Let us further assume that the total number of clients served by Y reference prevention agency during the last fiscal year (TY), irrespective of ethnic background, is 300. The expected number of ethnic/racial clients to have been served (EX) would be 60 individuals, or 10 percent of the 600 individuals who belong to a particular ethnic/racial population group. Suppose 40 Asians have been served by X prevention agency during that year (AX). This would then indicate an MSS rate of 66.7 percent (i.e., 40/60 x 100).

Cultural competence of a prevention agency may also be measured in terms of the past and present performances of an organization established to enhance the services rendered to the Asian population. Some potential indicators along the topic areas of needs assessment, training, staffing patterns, and prior performance may include the following:

Needs Assessment

1. Has the agency done a formal needs assessment during the past 3 years pertaining to the Asian population it intends to serve?
2. Are data collected and kept for ethnic/racial populations?
3. Are the collected data compared with comparable data from the population at large?

4. Are the collected data used in the annual reports?
5. Are the collected data used for self-evaluation?
6. Are the collected data used for planning?

Training

1. Has the agency required any training to enhance the cultural competence of its professional staff during the past 3 years?
2. Have board members been trained in cultural competency during the past 3 years?

Staffing Patterns

The following questions deal with the degree to which organizational staffing represents the population to be served.

1. What percent of Asian professional staff is employed in a prevention agency serving the Asian population?
2. What percent of the staff is bilingual?
3. What percent of the staff is trained in cultural awareness?
4. What percent of Asians is represented in an ethnic/racial advisory council?
5. What percent of Asian board members is on the board of directors of a prevention agency serving a particular community?
6. What percent of Asian Americans is represented at the administrative (or decisionmaking) level of the prevention agency?

Prior Performance Patterns

1. Is there linkage with other Asian organizations in the community that serve the same Asian group?
2. Are contract awards given to ethnic/racial service providers for issues specifically related to them?
3. Does the agency expend funds on behalf of ethnic/racial clients or communities?
4. Does the mission statement of the organization provide for culturally competent services?
5. Does the agency adjust holidays to accommodate cultural differences?

6. Is the prevention agency performance evaluated by the target population? That is, what is the target population's perception of the agency's effectiveness?
7. Is the agency located in the community it serves, or does it have a satellite facility where the target population goes?
8. Do service hours reflect client accessibility?
9. Does the agency display artworks reflecting the culture of the target population?
10. Does the agency distribute educational materials (e.g., pamphlets or brochures) in languages that its target population understands?
11. Does the agency have an in-house ethnic/racial researcher to add to the knowledge of culturally competent practices by conducting research and developing new and innovative approaches based on cultural idiosyncrasies?
12. Does the agency seek to improve relations between and among cultures throughout the larger community?

Management Strategies for Improving the Evaluation of Community-Based Prevention Programs

There are numerous ways in which cultural appreciation can be promoted in the evaluation context. Cultural sensitivity will influence the choice of particular wordings used in any evaluation instrument. To be culturally sensitive, evaluators need to look at the practices, attitudes, knowledge, skills, and aspirations of the target population before deciding on potential indicators of program success.

To achieve this end, evaluators should consult with community-based organizations and informed personnel regarding data collection and the kind of dependent variables they think may be indicative of program successes and failures. Such questions need to be directed to the program staff, the program director, the board of directors, and funding sources, as well as to the program participants. The important task of all evaluators is to interpret the data within the constraints imposed by the kind of theoretical approach and prevention strategy (model) the program has assumed.

To improve the quality and quantity of evaluation data that are generated, we focus on two strategies: those to improve the data-collection process, and those to promote subject participation and retention during the evaluation phase.

Strategies To Improve the Data-Collection Process

Self-Disclosure Methods

Numerous problems can occur when using self-report measures with certain Asian groups. First, there is the problem of language when the study subjects' primary language is not English. In such cases, one could use the following methods and materials:

1. Self-disclosure instruments that are translated to meet cultural conceptual equivalence. Such forms need to be in both English and the native language, and two versions must be offered simultaneously in all cases. The choice of which version to use must be made by the subject in a comfortable setting and in the absence of any interviewer, counselor, or other third party.
2. Bilingual machines such as tape recorders or voice-activated recorders with prerecorded messages and questions.
3. A bilingual interviewer conducting a face-to-face or a telephone interview. This method may elicit less reliable information than the above two alternatives unless subjects have complete anonymity. We have already noted that Asians attach a significant amount of personal and social stigma as well as shame to mental illness and AOD abuse problems. Consequently, many researchers have questioned the reliability of self-report responses, which may vary greatly depending on the context (public or private) in which the self-disclosure data have been collected and the level of anonymity as understood by the subjects.

Ethnographic Observation

Another way to improve cultural appreciation is to practice what is sometimes called prior ethnographic observation. This involves evaluators actually living among the client population for a period as participant-observers without simultaneously engaging in formal evaluation activities. Prior ethnographic activities are undertaken before the formal evaluation begins. These activities may be thought of as part of the training activity that evaluation team members are likely to want to undertake to increase their understanding (Guba and Lincoln 1989).

In engaging in such prior ethnographic observation, an evaluator may learn, for example, about the usual hangouts or neighborhood shopping centers where local people gather and engage in drinking behavior during typical weekends. Over time, the evaluator may collect data on the number of beer cans and liquor bottles found in these places on early weekend mornings to determine any changes in behavior. The actual counting can be accomplished by a team of paid local residents at different places within the project site. (This very act may be considered a process of empowering the evaluation task, which we will elaborate on shortly.) A systematic observation of the variable at regular intervals and at multiple locations may provide powerful data (that satisfy not only the scientific but also the indigenous target community) for determining the relative impact of the program's success or failure.

Need for Both Hard and Soft Data

Any data collected by evaluators of community-based prevention projects need to satisfy the interests of both the indigenous and the scientific community. For this to happen, any viable project needs to collect multiple "hard" criterion measures. These may range from individual attitudes and behaviors to aggregate system-relevant data. For evaluation purposes, however, we should also use "nontraditional" methods of data gathering: anecdotal data, key informant data, and data reported by other governmental and nongovernmental agencies such as those engaged in law enforcement, corrections, mental health, public health, social services, child protection, income maintenance, and rehabilitation.

In cases in which there are limited funds to undertake communitywide, systematic evaluation research, one usually depends on key informants such as community workers, teachers, probation officers, and police. One way this is done is to enlist the aid of either paid or volunteer local informants, who will serve as critical observers of the program's impact. Another way is to enlist the aid of the local leadership, persons who are bona fide members and leaders of the community and who are willing to serve as teachers and guides for the professional evaluators as they become oriented.

Informants and local leadership, however, may have their own reasons for serving in that role, which may not always be in the best interests of the evaluation. A care, therefore, must be given in the selection of such informants. It is also very important to train the informants to obtain more standardized data and to produce uniform reports. In using key informants, prevention evaluators need to be aware that incidents involving Asian youth at high risk for AOD use are usually underreported due to the Asian family's denial of the problem and extreme resistance to outside interventions, especially from WAAM social service agencies.

Empowerment of Evaluation Task

We also recommend a process type of evaluation to be conducted in cooperation with the indigenous people. This would use focus groups (e.g., progress-monitoring meetings) to review and revise the program activities that complement the project's objectives. In short, much of process evaluations can be accomplished "by the people for the people" in periodic roundtable meetings.

Prior to the actual data gathering, evaluators should describe to the program's stakeholders and target population the ends to which such data will be used. These descriptions should cover such topics as, Why do the evaluation? What do we want to learn? Who will use this information? and so on. It is also useful to have evaluation instruments that help local agencies isolate their community's needs.

Strategies To Promote Subject Participation and Retention During Evaluation

Listed below are some strategies used to initiate indigenous involvement and to enhance the retention of program participants during evaluation. Several of these strategies have been used effectively by a number of Asian community-based prevention projects in such cities as Los Angeles, San Francisco, and Salt Lake City.

Preference for Private Settings

Because Asians feel more comfortable in private than public, they generally prefer private meeting facilities. Thus, especially in the early stages of program evaluation, convening meetings in the home is preferred to holding them in public places.

The Need for Refreshments

For most Asians, food and refreshments play a very important role in social gatherings. For meetings held outside the home, light refreshments (such as sliced fruit) enhance the process and the interaction among participants.

Personal Touch/Connections

For some Asian groups, formal appointments and formal meetings are alien concepts. Accordingly, informing these people through a formal letter that their presence and participation in a formal meeting is expected may not work at all. At least such a formal announcement needs to be followed up by a personal visit, telephone call, or word of mouth, especially from those who are close to the potential participant. Face-to-face contact and personal pleas or requests work far better than a traditional letter announcing a meeting (a WAAM approach).

Compensation for Services Rendered

It is advisable to pay participants for the time they have given to completing evaluation tasks. Because concepts such as research and evaluation are not important to many Asian Americans, they would not participate just to add to the body of knowledge. But Asian Americans do have respect for a job, and they will do the best they can if they are paid to do the task.

Logistical Support: Transportation and Child Care

As already noted, evaluation meetings should be held in homes or in other informal settings whenever possible. If meetings are held at a formal facility, it is advisable to provide refreshments, transportation, reimbursement for babysitting, or child care at the meeting site. Many Asian families are accustomed to having children present at semiformal meetings.

Following these guidelines, for example, an initial strategy to induce indigenous participation might be based on a semiformal meeting with an invited guest speaker on a topic that is dear to the targeted Asian community. Such a topic may be parenting, the generation gap, discipline, or cultural values. It is almost imperative that food be served and shared among the participants. Following such a meeting, one may begin a signup list for support groups, future workshops, or training.

Methodological Issues for Improving the Design of Community-Based Prevention Program Evaluations

In previous sections, we examined the aspirations of Asian Americans and the theoretical orientation and prevention strategies of programs designed to serve them. These factors have been shown to have a direct bearing on the selection of relevant dependent variables and the operationalization of the outcome variables selected. In all cases, prevention evaluators should also be able to tell whether a particular dependent variable relates to the professed ultimate goals of the project or to the instrumental goals that help further them. Moreover, depending on the particular program's design effect (Cohen and Cohen 1983) (i.e., its intensity, duration, and scope), there usually are limits to what one can expect as reasonable outcomes. In this section, we examine each of these issues. Of particular importance is the need to use single-system evaluation designs. These designs will be especially useful when the need for control groups is not easily met, as often happens in Asian-American AOD abuse prevention programs.

Selection of Dependent Variables: Ultimate and Instrumental Goals

It is true that all AOD abuse prevention programs strive toward the ultimate goal of reducing AOD use or delaying its onset. It is also true that, unless one knows something about the causal links or factors contributing to AOD abuse within a particular client pool, one cannot identify appropriate programs to realize either the ultimate goals or the instrumental goals that help bring them about.

In the context of large-scale AOD abuse prevention programs, ultimate goals may include a reduction in the communitywide use of alcohol and other drugs, a delay in the onset of such use, a reduction in the frequency of death certificates that identify the cause of death as drug overdose or other AOD-related effects such as respiratory collapse, or a reduction in the number of beer cans and liquor bottles found in the usual community hangouts. Instrumental goals, on the other hand, are associated, concomitant, or constituent results that are deemed necessary for the ultimate goals to be realized. As such, they must be used as intermediate or instrumental dependent variables. Instrumental dependent measurements, for example, may include employment rates, changes in employment and legal status, changes in living conditions, the number of Asian Americans who have participated in WAAM culture awareness training, the number of parents participating in parenting courses, the student dropout rate, the number of new projects initiated by the indigenous population, and so on.

It must be made clear that an instrumental goal within a particular prevention project may serve as an ultimate goal from a different viewpoint. Whether a goal is considered instrumental or ultimate depends on the professed mission and particular prevention strategies of each prevention project.

Understanding the ultimate and instrumental goals will also help differentiate between program failure and theory failure regarding a particular prevention project serving a particular client pool. Program failure will obviously result if the instrumental goals are not realized. Theory failure will result if the ultimate goals are not realized, even though the intervening instrumental goals are.

By way of example, we refer to the family-oriented prevention approach. As noted previously, this approach is based on the idea that the Asian family unit is the pillar of strength and stability for all its members and therefore plays a critical role in the ongoing development and support of the child even into adulthood. Furthermore, Johnson and Nagoshi (1990) assert that the existence of extended families among Asian Americans contributes to reduced alcohol consumption. If there are few elders in some Asian communities, or if the elders who are present are disregarded, this may indicate an erosion of such family systems. Over time, one may measure the degree to which there has been an attitudinal change among youth in terms of their respect for the elders in the community. A greater respect at a later point in time may serve as an instrumental indicator of the program's success, although not necessarily of its ultimate success in reducing the AOD-using behavior of the client pool.

Selection of Dependent Variables: Program Design Effect

Program Intensity and Duration

Depending on the intensity and the duration of a particular prevention project, there is a gradation of outcomes expected. The outcomes can range from (1) changes in actual AOD-using behavior, to (2) changes in intentions to use alcohol and other drugs in the future, to (3) changes in the attitudinal makeup or high-risk syndromes that are closely related to the AOD-using behavior of a particular client base, to (4) improvement in the knowledge base (more pertinent information) as a result of the prevention project.

Frequently, prevention programs are offered on a piecemeal basis for only a short time. For example, many school-based programs are of low intensity and short duration (one school semester, a yearlong program, etc.). In such cases, it would be foolhardy to expect a wholesale change in AOD-using behavior. Perhaps it might be more reasonable to expect some changes in the intentions to use alcohol and other drugs in the future or in the attitudinal syndromes that are closely related to the AOD-using behavior of that particular client pool.

In programs that are based on the information deficit model, one may be able to use knowledge gain as one of the dependent variables. However, it is well known that any cognitive program is capable of bringing about knowledge gain over time. Such a finding may shed some light on the instrumental goal of the implemented project (i.e., success in one aspect of the process evaluation), but it would hardly constitute a success in changing the AOD use pattern of a particular client pool. Nor would it indicate an advancement in the knowledge base of the prevention field.

Scope of the Program

In determining the outcome of a prevention project, the evaluators should also be able to determine the scope of its impact. This scope may range from micro level (individual), to group level, to macro or systemic level (community-at-large). Assuming a community-based prevention project based on the empowerment model, for example, one may include the following measurements as potential dependent variables at these three levels.

Micro level (individual).

- ♥ Enhanced sense of community.
- ♥ Increased access to and use of mental and AOD abuse services.
- ♥ Decreased incidence of gang involvement.
- ♥ Increased individual participation in counseling or job training opportunities.
- ♥ Decreased use of alcohol and other drugs.
- ♥ Decreased prevalence of school failures, low school achievement, and student dropout rates.

It must be noted that many of the outcome variables measured at this level can also be collected at the aggregate, or macro, level.

Group level.

- Increased frequency of group sports or recreational events.
- Formation of supportive, group learning, and self-help groups for children, adolescents, and parents.
- Formation of groups for parents and youths to deal with acculturation issues.
- Establishment of Saturday/Sunday/evening schools for native and English languages.
- Increased cultural events, such as conferences with invited speakers who promote cultural pride, identity, or self-help.

Macro level.

- Establishment of a task force on alcohol and other drugs appointed by the chief executive officer of the self-governing unit that includes the Asian community.
- Reinforcement or establishment of a government agency that specifically deals with AOD use among Asian Americans at the appropriate government level.
- Public policy changes that relate to the Asian community.
- Increased networking with the social service agencies of the larger society.
- Cultural sensitivity training to the WAAM social service agencies.
- Creation of community-based organizations that promote the special interests of the Asian community.
- Increased proportion of owner-occupied properties in the target area.
- Percent of single-parent families in the target area.
- Unemployment rate in the target area.
- Average monthly rental fee for a two-bedroom apartment in the target area.
- Frequency of drug trafficking as reported by the local newspaper.
- Frequency of reported gang activities, shootings, or prostitution.

- Frequency of human traffic in local bars that are frequented by drug dealers and customers on certain hours and weekdays.
- Behavior of crime rate within the target community.
- Dropout rate or any changes in the average daily attendance rate as reported by local schools in the target area.

Improvements Needed in Data-Reduction Strategies: The Need for Single-System Evaluation Design

In evaluating Asian community-based prevention programs, there will be few opportunities for a control group because of the uniqueness of the population served. Accordingly, determination of the treatment effect (i.e., effect of the program) needs to be based on a single-system evaluation design that does not involve control groups. Listed below are examples of data-reduction strategies that can be used in conjunction with the single system-evaluation design.

Longitudinal Studies

In the absence of or difficulty in employing control groups in evaluation research involving Asian Americans, program evaluators need to place greater emphasis on longitudinal studies with periodic data collection to establish a baseline and a trend. For example, there need to be more longitudinal studies based on both reliable baseline information about the AOD use level and the systematic collection of similar data in subsequent years. Such a longitudinal data set could be a valid asset in determining the treatment effect over time.

Individual Growth Curve Models

Another single-system evaluation design that can be applied in both short- and long-term outcome evaluations is the individual growth curve models used successfully in educational research (Anderson et al. 1980; Bryk and Raudenbush 1987; Bryk and Raudenbush 1988; Bryk and Weisberg 1977; Bryk et al. 1980; Kim 1991; Kim et al. 1990; Strenio et al. 1983). In this design, the treatment effect of a project is determined by the difference between the posttest and pretest scores, which are, in turn, adjusted by a natural maturation rate predicted from individual growth curve models based solely on pretest data distribution. The individual growth curve models are based on ordinary least squares of the dependent measurement on age and other age by socioeconomic/demographic interactions (first-order and some second-order). The basic premise of individual growth curve models is that treatment effect can be determined using only the experimental group as if the experimental group were subjected to a control status.

Meta-Analytic Controls

An alternative way to estimate the treatment effect without a control group is to estimate the expected changes in the pre- and posttest scores based on a meta-analytic review of existing literature along the attitudinal and behavioral measurements that are used with similar groups in the target population and with the similar scale or measurement used in the program being implemented (Kim et al. 1992). Owing to the uniqueness of the Asian-American groups, such may not be readily available. However, an extensive search of other programs and reports of published data along scales similar to those used in the particular program can give some information as to the behavior or general tendency of these scales over time. Specifically, the information we will be looking for would be the tendency of the similar scale/measurement scores and their changes over a given period for a given population: Do the scale scores change (i.e., go down or go up) or remain at about the same level between the test periods? If they change, is the change one-third, one-quarter, or one-eighth of a pooled standard deviation based on both the pre- and posttest scores? Such information can be obtained from both control or ineffective experimental groups observed in the published evaluation reports. Based on the average or general tendency of these scales, one can extrapolate the expected changes in the treatment group in the absence of a treatment and deduct the latter score from the observed score changes between the post- and pretests originating from the treatment group.

Conclusion: Future Evaluation Research Directions

In evaluating AOD prevention programs for Asian communities, we are painfully aware of the lack of both theoretical assumptions and associated basic research that could guide both the development of such programs and the related task of selecting appropriate outcomes measurements. In view of the underdeveloped state of the inquiry, the evaluation tasks are principally directed toward the blind determination of program success or failure without a real understanding of why the program succeeded or failed. In cases in which a program has failed, the evaluators may be unable to provide appropriate direction toward its refinement in the future.

In the process of increasing the knowledge base for prevention programs involving Asian groups, the first task must be to redefine and provide more detailed specifications for the ethnic diversities and immigration backgrounds embedded in the all-encompassing classification of Asian/Pacific Island Americans. All Asian Americans are not alike in their pattern of AOD use or in the attributes that appear to be predictive of the use of alcohol and other drugs. In fact, different factors predict different AOD use among Asian-American groups (McLaughlin et al. 1987). Prevention evaluators must therefore be aware of the differences among various Asian groups and within their generations. As noted, recent immigrants and refugees are more likely to handle problems within their own community, whereas those who have become more assimilated into the mainstream American society are probably more comfortable using available public services.

Accordingly, because the degree of access to public AOD abuse services depends somewhat on country of origin, immigration history, and assimilation status, evaluators need to consider differences in ethnic background, generational status, and degree of assimilation when examining AOD use and related problems among Asian Americans (Shon and Ja 1982). And, as already stated, this calls for a redefinition and a more detailed understanding and a description of Asian/Pacific Island Americans and of the diverse populations implied in that term, with special attention directed to immigration and refugee status. Asian/Pacific Island-American communities include Asian Indians, Cambodians, Chinese, Filipinos, Guamanians, Hawaiians, Japanese, Koreans, Laotians, Samoans, Thais, Vietnamese, and others from Melanesia, Micronesia, and Polynesia.

Another research issue that concerns evaluators is the current assumption by many Asian prevention projects that AOD use is most prevalent among anomic individuals and that enhanced identification with the native culture increases resiliency or serves as a "protective" factor that reduces the probability of AOD use. This kind of cultural paradigm is certainly consistent with the OCI theory developed by Oetting and Beauvais (1990) and with the prevention strategy based on the cultural enrichment model. However, there has been no empirical study of AOD-using behavior that has compared monocultural, bicultural, and anomic Asian Americans. Furthermore, such variations in cultural identification may well be confounded with socioeconomic and other demographic differences, not to mention with the many interactions present in these variables. Without such basic research involving Asian Americans, it is somewhat difficult to establish a firm foundation on which to base the refinement of future prevention strategies. Absence of a scientifically validated theory or a set of related theories means a difficulty in delineating the appropriate outcome variables, especially those instrumental goals to be used in the evaluation tasks.

It is also very important to note that the concept of acculturation constitutes one of the most important areas of individual differences within Asian groups. As such, there needs to be a greater dialogue along the conceptual as well as operational consensus if the prevention field is to advance toward the goals of AOD prevention involving Asian Americans.

In prevention projects involving Asian Americans, it has also proven to be particularly difficult to motivate client participation. Accordingly, we recommend that evaluators place a special emphasis on collecting sociodemographic lifestyle characteristics of participating and nonparticipating individuals and their families. Such knowledge will be an invaluable asset in refining prevention programs in the future.

Regarding family-oriented prevention strategy, there is also considerable confusion. As we have seen, Asian families and extended kinship networks have often been cited as an important protective factor against many mental health problems (Hsu 1973) as well as against AOD use. Yet they can also become a significant source of stress for the individual, as evidenced by intergenerational and family role conflicts (Lee 1982). Given this confusion, we need to elaborate more on the environmental and family conditions (e.g., generation, nationality, immigration history, country of origin, socioeconomic status, inter- or intraracial marriage, degree of acculturation) under which these effects are observed. In the absence of such elaboration, it is very likely that programs that have used family-oriented prevention models and have failed to produce an enhanced sense of family cohesiveness among their participants may never know why the model failed and how to remedy the problem.

Finally, we have to emphasize that whatever knowledge we have gained so far about Asian Americans and their use of alcohol and other drugs is based on surveys that have hardly included high-risk populations. This is because Asian groups that appear at highest risk for developing AOD problems and that actually abuse alcohol and other drugs have seldom been studied or have not been separately identified in previous research. In view of such a lamentable state of research on the etiology of AOD abuse among Asians, one may need to turn to more ethnographic studies and use evaluation strategies that depend on such studies.

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9

Cultural Competence for Evaluators Working With Asian/Pacific Island-American Communities: Some Common Themes and Important Implications

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Abstract

In the past, the field of alcohol and other drug (AOD) abuse prevention has not focused aggressively on the problems of the Asian/Pacific Island-American population. Program evaluators working with Asian/Pacific Island-American groups need both knowledge and skills that are not currently available in typical training programs. This chapter provides an overview of this complex problem and offers a number of solutions. The chapter is divided into two parts. The first part examines common themes and characteristics that are likely to arise when working with Asian/Pacific Island Americans. It reviews culturally specific factors and demographic variables within the context of AOD abuse treatment issues, and discusses significant similarities and

differences between population subgroups. The second part of the chapter examines the relevance and implications of these themes for the process of program evaluation planning.

Introduction

The field of alcohol and other drug (AOD) abuse prevention, treatment, and program evaluation has largely ignored Asian/Pacific Island-American populations. This chapter is written to provide the reader with both an overview of the complexities of the problem and some possible solutions. It is by no means a complete answer to the needs of the AOD problem prevention professional, but it may introduce the topic and provide an incentive for further investigation.

The chapter is organized into two parts. The first part examines common themes that may arise when working with Asian/Pacific Island-American populations. It reviews demographic and cultural issues with a focus on AOD abuse and its treatment or prevention. Where appropriate, it emphasizes differences and similarities between subgroups. The second part examines the implications of the issues discussed in the first part for program evaluation. It raises many of the questions that should be asked by any program evaluator, but it also focuses on the special needs and concerns of evaluators who choose to work with Asian/Pacific Island Americans.

The broad goal of this chapter is to further the practice of cultural sensitivity and competence in AOD misuse and abuse prevention and treatment programs serving Asian/Pacific Island Americans. This concept may be viewed as an active process that strives to maintain an awareness of the specific cultural values, beliefs, and practices of Asian/Pacific Island-American subcultures and to apply this information to all aspects of program decisionmaking.

Within this context it should be noted that answers to important questions may vary depending on the particular cultural group. For example, do members of the targeted culture measure alcohol in ounces or milliliters? Might members of the culture be uncomfortable answering a female or a younger interviewer's questions? Might it be considered impolite to address an individual by his or her first name? Would an individual feel free to ask for clarification of a question or would that individual consider it rude to do so? The culturally sensitive program evaluator must not only be able to answer such questions, but also be continually ready to ask new "culturally sensitive" questions and to seek their answers.

Although written ostensibly for the program evaluator, this chapter tends to blur the distinction between the service provider and the program evaluator. This is because making a clear distinction between program evaluators, program designers, and program providers in the field of AOD abuse is somewhat artificial and perhaps even unwanted. It is often the case that funding limitations make provision of an independent program evaluator impossible. In such situations, it becomes the responsibility of the program to evaluate itself, requiring administrative and direct service personnel alike to participate actively in the evaluative process. All too often, that process is viewed by frontline workers and administrators as judgmental or critical in nature. This chapter is written in hopes of encouraging those faced with the dual provider-evaluator role to embrace program evaluation as a positive developmental process that is essential to every program.

Common Themes

Throughout this chapter, the reader will note what might be called a consistent inconsistency. While the attempt has been made to present themes common to the Asian/Pacific Island-American population, this has been done without losing sight of the considerable diversity within this population. It is hoped that the resulting impression is one of a people who share some very general cultural similarities but who are also rich in their cultural diversity.

Demographics

Recent statistics indicate that Asian/Pacific Island Americans residing in the United States currently number close to 6.5 million. The Asian/Pacific Island-American subset of the population has demonstrated the highest growth rate of all ethnic/racial groups.

Not only is this population group growing at a very rapid rate, but the substantial immigration of Asians to the United States in the wake of political unrest and upheaval in Asia has unquestionably changed the character of the Asian/Pacific Island-American population. Sue and Sue (1987) note that more than 70,000 refugees from Southeast Asia have been admitted to the United States since 1975. This influx of immigrants has changed the demographic characteristics of Asian/Pacific Island Americans. Before this, this population was considered relatively stable and had shown only limited geographic mobility.

Prior to the period of immigration that began around 1975, most Asian/Pacific Island-American immigrants were Chinese, Japanese, Korean, or Filipino. Since the Vietnam War, a significant number of Vietnamese, Laotian, Thai, Cambodian, and Pacific Islander immigrants have also come to the United States. Many of these groups, throughout their history, have been influenced by the more dominant Chinese, Japanese, and Western cultures. As a result of this shared history, groups may share certain very general cultural similarities, but each regional group maintains a distinct cultural identity.

Demographic changes have also been noted within subgroups. The 1980 census indicated that over 60 percent of the Chinese in this country were recent immigrants. Thus, according to Yoshioka and colleagues (1981), the group collectively referred to as Asian/Pacific Island Americans comprises more than 60 distinct subgroups, each maintaining its own language, religion, and customs. Clearly, the term *Asian/Pacific Island American* represents a heterogeneous and rapidly changing group that defies all but the broadest attempts at descriptive generalization.

American society has generally viewed Asian/Pacific Island Americans as a financially independent group that is fairly free from psychiatric or AOD abuse problems. The relative paucity of AOD abuse-related research conducted within this population may be an indication of the widespread acceptance of this stereotypical view. Until accurate descriptive data related to the diverse composition of Asian/Pacific Island-American subgroups are accumulated, analyzed, and reported, the prevention or treatment program designer/evaluator must perform much of the groundwork. It is his or her responsibility to define the demographics for the targeted population.

Specific data describing the educational level, occupational trends, income, family structure, language, customs, religion, generational differences, patterns of AOD use and abuse, and attitudes toward alcohol and other drugs within the targeted group must be collected before designing a program. Thus, gaining a clear understanding of the targeted population is the crucial first step toward any planned evaluation, which itself should be a significant component of the design process.

However, the relatively recent changes in immigration patterns and their concurrent effect of increased cultural diversity among Asian/Pacific Island Americans place greater demands on the program designer/evaluator. The new immigrants come from many different walks of life, with varied levels of educational and vocational experience. Their backgrounds are markedly different from those of the immigrants of decades ago, who tended to have lower educational levels and who engaged in less skilled occupations. The differences between the "new" and the "old" immigrants make it difficult, if not impossible, for the program evaluator to design a single evaluative tool suitable for both populations.

Moreover, the changes in the demographic makeup of the Asian/Pacific Island-American population are not yet reflected in the research literature of AOD abuse. Of the relatively limited number of AOD abuse studies related to Asian/Pacific Island-American groups, most tend to concentrate on the Chinese-American, Japanese-American, or Korean-American populations. The influx of new groups from Vietnam, the Philippines, Thailand, and other areas of Southeast Asia, who have their own distinct cultural and psychological backgrounds, is only now being reflected in the literature. So the program designer/evaluator, in targeting one of the "newer" Asian/Pacific Island-American groups, has little in the way of specifics and must rely on his or her own ability to glean questions rather than answers from the existing literature.

Heterogeneity

The existing scientific literature related to AOD abuse in the Asian/Pacific Island-American population emphasizes the need for a subgroup-specific approach to program design and evaluation. The results of the following selected studies of alcohol consumption among Asian groups may serve to illustrate the diversity of possible factors involved.

Kitano and Chi (1990), in a study of four Asian/Pacific Island-American groups (Chinese, Japanese, Korean, and Filipino) in the Los Angeles area, report significant differences in their alcoholic drinking patterns. These authors found a higher percentage of drinkers than abstainers among Japanese and Chinese Americans, while the reverse was true for Korean and Filipino Americans. Within-group analysis yielded differences in gender and age characteristics for both abstainers and drinkers.

Lubben and colleagues (1989), in a study of the characteristics of Korean-American drinkers versus abstainers, report that males, especially those who go to bars or nightclubs, are more likely to be heavy drinkers. On the other hand, individuals who are active in sports and in the Protestant religion are more likely to be moderate drinkers or abstainers.

Chi and colleagues (1989) report that, among Asian/Pacific Island-American groups, heavy drinking is found most often among Japanese Americans and least often among those of Chinese descent. These authors further report that the only social factor identified in their study as being significantly related to Asian drinking is that of having friends who are drinkers. However, the variety of between- and within-subgroup differences illustrated in this sampling of recently reported research only begins to define the problem.

A number of researchers have more directly addressed the issue of defining which factors influence AOD abuse patterns among Asian/Pacific Island Americans. Sue and Nakamura (1984), for example, citing the "flushing reaction" to alcohol of some Asian groups, express the need to consider group differences in physiological responses for any comprehensive explanation of Asian/Pacific Island-American drinking behavior.

Johnson and colleagues (1987) argue against this genetic difference approach and stress instead the importance of cultural norms as possible determinants of drinking patterns and AOD abuse risk factors.

In a recent report, Kitano et al. (1985) suggest that, although many behaviors are essentially unaffected by geographic area (i.e., values, family roles), others such as alcohol consumption are significantly affected by the local environment. And from the behavioral perspective of the present author, local environment may be interpreted as one of those environmental contingencies that control behavior. This is because culturally influenced factors such as the association of AOD abuse with recreational activities, the availability of certain drugs, and peer influences may provide modeling and reinforcement of AOD abuse within the context of the local environment.

Core Elements of Culture

The heterogeneity of Asian/Pacific Island Americans makes it extremely difficult to generalize about cultural norms. The generally negative attitude Asian/Pacific Island Americans exhibit toward mental disorder may, however, provide insight into the Asian/Pacific Island American's attitude toward culturally undesirable behavior in general.

By and large, within the Asian culture, the family has profound effects on the individual's value and belief systems. Sue and Sue (1987) note that the Asian family associates shame and stigma with the admission of mental illness within the family. Such a cultural view of mental illness reinforces denial rather than open admission of problems. The tendency toward denial extends not only to elders and authority figures within the Asian/Pacific community, but also to outsiders, namely physicians and counselors, who are viewed as authority figures.

At first glance, such characteristics may appear to suggest the promotion of a stereotypical view of Asian/Pacific Island Americans. Nonetheless, based on years of close contact with Asian/Pacific Island-American communities, this author maintains that such phenomena still exist to a certain extent and should not be entirely ignored. This raises an important issue: The program evaluator is often faced with examining aspects of a culture that have been associated with what some may consider to be a negative, stereotypical view of that culture. The challenge to the evaluator is to address such factors in ways that clearly define their utility without overgeneralization and with a sensitivity to their interpretation.

Atkinson and colleagues (1990) studied Asian/Pacific Island-American acculturation and preferences for caregivers and other providers. They report that communication patterns for Asian-identified students reveal a reluctance to admit to and seek help for personal problems. The students in the study also tended not to communicate problems to their parents. Atkinson et al. (1990) suggest two possible explanations. The reluctance to communicate with family may reflect a culturally determined negative attitude toward "personal problems." Alternatively, it may be explained by the geographic separation of the students from their families and the resulting inability of the families to provide help. Within the mainstream majority culture, the tendency of the individual and family to deny AOD abuse problems is perhaps the most frequently cited barrier to seeking treatment. Thus, if there is an existing culturally determined tendency among Asian/Pacific Island Americans to deny personal problems, and if this is additive with the recognized denial associated with AOD problems, the treatment program must recognize this and establish means to help Asian/Pacific Island Americans overcome these multiple barriers.

Another finding of the Atkinson et al. (1990) study may suggest a means of increasing self-disclosure in Asian/Pacific Island Americans. These authors report that, once Asian/Pacific Island-American students had admitted to personal problems, they showed a preference for caregivers who were perceived as professional rather than as paraprofessional. Professional helpers apparently represent authority figures who are to be respected and who have the recognized stature to advise. The employment of professional counselors, especially in the intake process, may help the target population overcome the denial tendency. It may be that, once an Asian/Pacific Island American decides to disclose, it is more appropriate to do so to one perceived as an authority figure.

Although not yet empirically tested, this may be an area for future study in program evaluation. Studies that define "authority figures" for a targeted cultural group may prove beneficial and lead to incorporation of these findings into new approaches to the problem. Existing, culturally recognized authority figures (i.e., clergy, elders, traditional medicine men) may turn out to be a resource that has largely gone unrecognized.

Another aspect of the Asian culture that may present a barrier to the AOD abuse treatment professional is that of religion. Although Western religions have had some impact on Asian/Pacific Island-American culture and a number of Asian/Pacific Island Americans are Christians, traditional oriental religions remain more widely practiced and have the most influence on cultural values and beliefs. Hoang and Erickson (1985), for example, in a report on cultural barriers to providing effective medical care to Indochinese patients, note that many Indochinese make little distinction between medicine and religion. With this in mind, the helping professional working with Asian/Pacific Island Americans must be aware of the general religious beliefs and practices of the specific target population, and the program evaluator must assess the means used by programs to maintain this awareness.

Cocultural Dynamics

Although acts of oppression and racism against Asian/Pacific Island Americans have rarely been reported in the news media, some prejudicial attitudes and behaviors certainly do exist and may, in fact, be on the rise. Recently, reports of acts of violence against Asian/Pacific Island-American owners of local markets in predominantly African-American communities have surfaced, suggesting increased tension. Similarly, the much-publicized controversy over automobile advertisements that were viewed as anti-Japanese also suggests that views toward the Asian/Pacific Island-American community are possibly changing. That Asian/Pacific Island Americans have always relied on education as a means of coping with the general American culture has been generally recognized in the mass media. Now, however, this emphasis on academic excellence within the Asian community may be inadvertently leading to an increased rift between the mainstream culture and the Asian/Pacific Island-American populations. Reported claims of discriminatory admission practices against qualified Asian applicants to a number of institutions of higher learning recently have appeared in the media.

Prejudicial attitudes toward Asians may not be common within the mainstream culture. Nevertheless, the AOD abuse practitioner and evaluator alike must be increasingly aware of the need to assess the client's perceptions of prejudice and attentive to how the program may reinforce such perceptions.

Micro-Level Social Structures

A number of studies have examined age, gender differences, and family structure as they relate to AOD abuse in the Asian/Pacific Island-American community. Kitano and colleagues (1985), cited earlier, report that Japanese-American males drink alcohol more often than Japanese-American females. Drinking per se was not viewed within the culture as associated with problems; however, the authors note that individuals who were experiencing personal problems tended to develop AOD abuse problems.

Sasaki (1985), in an intercultural study of mainland Japanese and Japanese Americans, reports similar findings that females in both cultures tend to drink less frequently. The author reports that the motivation for drinking is generally bound to social functions since drinking is viewed by both groups as a way to establish strong interpersonal relationships. Sasaki also emphasizes the importance of alcohol consumption as a part of ceremonial and traditional events. Such events are highly valued social occasions, and their impact on the individual's attitude toward drinking cannot be ignored by the AOD abuse treatment program.

Lubben and colleagues (1988), in a study of Filipino-American drinking, interviewed 298 adults and noted that approximately 50 percent of the females in the sample were abstainers whereas 80 percent of the males were drinkers. Heavy drinking is almost exclusively identified as a male activity. However, regular participation in religious services is a discriminating factor between moderate versus heavy drinkers, as those who regularly attend religious services tend to be moderate drinkers. These results again illustrate the importance of both gender and religious factors when treating the Asian community.

Two studies of the Chinese-American family may be used to show how a positive outcome can result from awareness of cultural factors. Noting the high degree of structure existent in the Chinese-American family, Shinn (1990) discusses the family's vulnerability to multiple stressors caused in part by rapid changes in the level and nature of intergenerational tension. This is reported to be especially true for the newly immigrated family.

Chng (1986), in a study of the Chinese-American family and alcoholism, confirms the highly structured nature of the family within this subgroup. However, this author further reports that the alcoholic in the Chinese-American family responds positively to structured family therapy. This incorporation of the existing cultural norm into an effective therapeutic approach is a good example of the kind of intervention strategies needed when working with an ethnic/racial population.

Class Differences Versus Cultural Differences

The issue of social class differences versus cultural differences has a number of dimensions. For example, class differences within a subgroup may have a significant impact on design treatment programs. Class differences among Asian/Pacific Island Americans are perhaps not readily obvious to those in the mainstream American culture. In many Asian subgroups, however, there exists a line separating professionals from paraprofessionals and blue-collar workers. Although it is true that this type of social class distinction exists within the White Anglo-Saxon mainstream culture as well, the AOD abuse worker should be aware that it is much more commonly observed and strictly enforced within many Asian groups.

There may also exist deep-seated feelings of animosity between members of certain Asian/Pacific Island-American subgroups. Such animosities may be rooted in past historical events related to long-term occupation during war or may be the result of religious or political differences between factions in their native country. In a field in which group treatment is the norm rather than the exception, the AOD abuse treatment staff must be aware of potential conflicts that may negatively influence the therapeutic process.

The strong work ethic demonstrated by many Asian/Pacific Island-American groups has implications for the AOD abuse program. Many Asian immigrant families work long hours 7 days a week to establish a family business. Many Asian/Pacific Island-American students, striving for the cultural ideal of academic excellence, spend most of their free time studying. The pressures to succeed, both financially and culturally, may make the potential client less available for treatment during the more commonly established daytime or early evening hours of operation. Thus, the particular work patterns and hours of availability of the target population must be given special consideration by any treatment program working with the Asian/Pacific Island-American population.

Similarly, cultural and class differences may exist between program staff and ethnic/racial clients. Although these differences cannot be eliminated, the treatment staff have a responsibility to become culturally sensitive to the needs of their clients and to the potential cultural barriers to effective treatment. Traditionally, health and mental health researchers have seemed to concentrate on the mental health and drug issues of mainstream Americans. Yamamoto and Steinberg (1981), in a study of ethnic, racial, and social class factors in mental health, note that African Americans and other ethnic/racial populations have generally been excluded from the scholarly evaluation of social class factors in alcoholism, drug abuse, and mental illness. Professionals in the AOD abuse field tend to ignore the specific subcultural backgrounds and needs of the clients served when analyzing and interpreting research results. Only when additional studies of specific subgroups are completed and disseminated will mainstream, middle-class professionals and paraprofessionals who conduct AOD abuse treatment have the resources necessary to identify with their Asian/Pacific Island-American clients.

Effects of Immigration and/or Migration

New immigrants typically suffer from several different types of stress (Shinn 1990). These may include language differences, cultural differences, economic hardship, and increased intergenerational tension, as noted throughout this chapter. One stressor, relatively unique to the newly immigrated, is that of the split family. Most Asian/Pacific Island-American immigrant families are split households; one member typically immigrates to the United States and is later joined by additional members. The period of separation from family may be years. The stress of separation may be especially significant within a culture in which so much of social life centers around the family, and it may be a risk factor associated with AOD abuse.

A similar problem occurs as a number of Asian families send their children to American colleges and universities. As a result of this practice, many Asian students spend the school year in the United States and migrate back to their native countries in the summer and during semester breaks. Although this differs from what is typically viewed as migration, both the separation from home and family and the repeated travel can cause a high degree of movement-related stress.

For the purposes of this review, no studies were found that identified the possible association between this type of migration and substance abuse. However, it should be noted that only with an awareness of this pattern of Asian/Pacific Island-American behavior would the question of such a relationship be raised. And only culturally sensitive service providers and program evaluators will have the background and contextual information necessary to raise it.

Language and Dialect Issues

Language and dialect are two related issues that are likely to influence any AOD abuse treatment or prevention program targeting Asian/Pacific Island Americans. The Chinese language alone has several different spoken dialects—e.g., Cantonese, Toishanese, Mandarin, Shangainese, and Taiwanese (Fookienese)—that are commonly used by Chinese Americans. In some cases, even fellow Chinese Americans cannot verbally communicate with each other. When one considers the number of dialects that are probably used among the approximately 30 subgroups of Asian/Pacific Island Americans, one may begin to see the extent of the problem.

Differences may extend to the written word as well. For example, an Asian/Pacific Island American of Cantonese origin may perceive Chinese writing in Mandarin style with less enthusiasm. Prevention materials published with all good intentions in a native language may not have the intended effect due to the use of a style that is less accepted by the target population. Although such effects may be subtle, the nuances of culture must be considered.

The underlying language patterns within a culture or in cross-cultural exchanges must also be considered. Hoang and Erickson (1985) found that Southeast Asians may respond "yes" to questions as a means of avoiding conflict or acknowledgment of misunderstanding. The unaware AOD abuse worker may take this response to be an affirmation of the question, thereby totally misreading a situation. Lee (1986) stresses the cultural suppression among Chinese Canadians of emotional responses and the cultural taboo against discussing one's personal feelings. The author emphasizes the need for awareness of nonverbal cues such as body language when working with Asian/Pacific Island groups. By increasing skills in this form of communication, an alert staff member can often benefit by increasing his or her ability to gather accurate information.

The obvious solution to the problems of language differences between program and community is to employ a native language speaker. This may be more difficult than it seems. It is not always possible to find a trained AOD abuse professional or paraprofessional with the appropriate native language. One solution is to develop AOD abuse treatment and prevention programs for members of the target ethnic group.

Age and Gender

It is important to consider age and gender variables when designing any AOD abuse prevention or treatment program. When working within the Asian/Pacific Island-American population, this may be doubly true. As noted above, Kitano and Chi (1987) studied the drinking patterns of different Asian/Pacific Island-American subgroups. The gender differences they report were reviewed earlier in this chapter, but these authors also report significant age differences related to alcohol consumption among the different ethnic groups studied. Their results exemplify the importance of considering age factors in this context. Kitano and Chi (1987) report that male Chinese drinkers, both heavy and moderate, tend to fall between the ages of 26 and 35. Male Korean heavy drinkers tend to fall between the ages of 36 to 45 whereas moderate drinkers tend to be older than 56. Male Japanese of all adult ages may be heavy drinkers, and most Japanese moderate drinkers are between 46 and 55 years old.

Faced with such data, the prevention specialist must tailor any program to be not only culturally relevant but also age appropriate to the targeted Asian subgroup. For example, factors such as age and gender of counselors, primary language of clients, and position of clients in their family hierarchy may have varying levels of treatment significance, depending on both the culture and the age of the target group.

Summary

This has been a brief overview of a complex picture of the diverse Asian/Pacific Island-American population. The focus has been on raising questions and issues for the reader rather than on providing an all-encompassing description. It is hoped that AOD abuse workers, either those providing treatment or those designing prevention programs, will appreciate the complexities of their targeted subgroup and seek a broader understanding of that subgroup's culture independent of AOD abuse. Such an understanding will not come easily, but little of value ever does. The professional in the AOD abuse field, to reach a level of sensitivity necessary for effective intervention, must ultimately know his or her client.

Implications for Evaluation

Appropriate Variables and Related Measures

Prior to discussing the understanding and translating of cultural content and context, it should be noted that there are several kinds of program evaluation: needs assessment, evaluation of the availability and strength of current programs, and prevention and treatment program evaluation.

Needs assessment is a first step toward evaluating any health service delivery system, including AOD abuse prevention and treatment. A review of grant guidelines for AOD abuse prevention programs funded by both the National Institute on Drug Abuse and the Office for Substance Abuse Prevention has clearly indicated that the needs assessment component has been required for all demonstration programs. However, communities conducting needs assessment, especially on the sensitive topic of AOD misuse and abuse, are likely to meet with resistance, and Asian/Pacific Island-American communities are certainly no exception. Although a community may be interested in receiving funding for program development, it is equally concerned that a negative image of it may result from the needs assessment. "Community" here refers not only to the residents but to different institutions as well. For example, this author vividly recalls that one of the school districts in the State of Maryland has resisted the State's efforts to provide a survey of AOD abuse among its teenagers.

Several approaches may be used to overcome this difficulty. If a direct survey is to be used, a presurvey promotion must be made through local civic organizations, local Asian language newspapers, and television and radio stations. Unfortunately, the return rate of any mail survey has traditionally been less than 10 percent. If it is assumed that the percentage will be the same in Asian/Pacific Island-American communities, there then remains the risk that older generations may be underrepresented. This is because, based on personal observations, many older and first-generation Asian/Pacific Island Americans among some subgroups are more reserved and private, so the act of revealing sensitive information such as AOD use may be especially difficult for them. Even when interview techniques are used, the Asian/Pacific Island Americans' attitude against self-revelation of embarrassing information would likely interfere with the process.

Another alternative is to include the AOD abuse program needs assessment as part of a less sensitive general health survey. Additionally, a broader AOD abuse needs survey may include other public information, such as records of those who were driving while intoxicated, police reports on domestic disputes, AOD abuse-related arrests, and emergency room hospital admissions. Again, caution must be exercised because these records are at best measures of neighborhood exposure to alcohol and other drugs rather than indications of the number of individuals involved.

Information concerning the demographics of client populations served by existing AOD abuse programs is relatively easy to obtain. However, evaluating the efficacy of these programs is more difficult as it requires some form of clinical evaluation. Clinical evaluations of these programs have been primitive at best, and the few evaluations of Asian/Pacific Island-American AOD abuse programs are no exception. Although almost all of the reported programs performed evaluations, the evaluations usually concentrated on the activity participation rate. Thus, several important types of information were missing.

Although different evaluators have different points of view on what types of data should be collected, Yen and colleagues (1989), in a study of an AOD misuse/abuse prevention program in a correctional setting, recommend that the effectiveness of program implementation should be assessed by both process and outcome evaluations. Process evaluation measures the degree to which the program operates as intended. Thus, staff ratings of client participation and client ratings of group leader skills make up this evaluation component. Outcome evaluation looks at knowledge and attitude changes brought about in the program. These changes are measured by objective assessment, using a pre- and postintervention test analysis, and by subjective assessments, using client and group leader estimates of attitudinal and behavioral changes. Because of the limitations in their setting, long-term followup evaluation was not included in Yen et al.'s (1989) study, but it should be included whenever possible.

Almost without exception, the reported program evaluations included no cost-benefit or cost-effectiveness analyses. Neenan (1974) notes that the basic concept of cost-benefit analysis is a systematic attempt to compare the inputs of any action with its outcomes in terms of a commensurable unit, usually monetary. The purpose of such analyses is to determine which programs achieve the most benefit for a given cost. Thus, a program that achieves somewhat less but at a much lower cost may be judged more effective in terms of what can be achieved with a given level of expenditures.

McLean (1974) notes that cost-effectiveness depends on a reasonable measure of therapeutic efficacy, which in turn depends on followup information. Cost-benefit analysis, therefore, must be conducted after clinical evaluation. Given the limited availability of funding, it is imperative that program evaluation allow a degree of cost-benefit comparison between programs with similar targeted problem areas.

Silverman (1988) notes that inadequacies exist in the conceptual bases for the development of interventions and in the degree of specificity and linkage of the intervention to the hypothesized etiology. To understand and translate cultural content and context, Tucker (1985) notes that AOD use treatment and prevention programs must be designed from a knowledge of why individuals or particular classes of individuals use particular substances.

In reference to service delivery, two basic ethnicity-focused treatment issues are in need of empirical exploration: what factors are most likely to influence treatment outcomes for ethnic/racial populations, and what ethnicity-specific innovative therapies are successful.

In keeping with comments made earlier in this chapter, Penk and colleagues (1981) feel that environmental influences on AOD use behavior are of greater significance for ethnic/racial populations than for Caucasians, whose behavior may be more suitable for psychodynamic interpretation. Accepting that the influence of environment on the AOD abuse behaviors of Asian ethnic subgroups may be stronger, attitudinal measures may not be as useful as behavioral change measurement procedures in assessing outcome. An advantage of a behavioral changes approach over an attitudinal measures approach is that the former may measure behavior that is more directly related to environmental factors influencing Asian/Pacific Island-American AOD abuse behavior. A change in attitude, however, may be less likely to reflect behavioral change in Asian/Pacific Island Americans when environmental factors remain unchanged.

Potential Side Effects of Conventional Approaches

Kazdin (1984), in a discussion of assessment- and diagnosis-related issues, comments that traditional assessment devices such as personality tests are assumed to assess general personality patterns, and that the results obtained from their use are considered to reflect performance in situations that are not directly observable. However, there is no assurance that how one performs on a questionnaire will predict how one actually behaves in the real situation. Kazdin further notes that a main criticism of diagnosis is its implicit adherence to the model used for physical disease.

Yet many problems that people bring to treatment reflect complex processes in their interpersonal environments. Given this line of argument, administration and interpretation of test scores must be used with extreme caution. The reader should be wary regarding the safety and efficacy of traditional psychological tests and should use techniques that can be validated if at all possible.

Nevertheless, there are times when some types of attitudinal evaluation scales are necessary for a variety of reasons. In these cases, Yee and Thu (1987) suggest several assessment instruments appropriate in identifying correlates of AOD use and abuse among Indochinese respondents: an adapted version of Kinzie's Depression Scale, a coping scale that includes strategies to diminish problems caused by the use of alcohol and other drugs; the Solvable Problem Scale, which includes items measuring problems with American ways of living; and the Manner of Assistance Scale, which includes items on how the respondents get help in solving problems.

Aside from general problems associated with the evaluation instruments, Zane and Sasao (1990) note several problems associated with conventional measurements. For example, the self-report format has been commonly used in the AOD abuse prevention and treatment field, but Asian/Pacific Island Americans may have problems responding to the survey because "most East Asian languages are very contextualized in that the context often established the tensed status of the person" (Zane and Sasao 1990). Zane and Sasao use the example of responding to the item, "I have difficulty making decisions." An Asian respondent would want to know the time period involved (e.g., during which month) and the type of decisions considered (e.g., financial, career, or family) before making an appropriate response. Therefore, if a conventional type of evaluation is used, sensitivity must go into constructing survey questions.

Another interesting issue is the self-disclosure of sensitive problems. Because of their personality constitution, Asians may be less comfortable with self-disclosure. Evaluation may have to include examination of the utility of alternatives to traditional written and face-to-face interview data-collection techniques, depending on the target population.

Asian-American subgroups may contain a significant degree of within-group variation in terms of language. Even among members of the same family group, reliance on spoken and written regional variations of the native language may be more evident in older generations than in younger generations with more formal education. Evaluative tools must consider these variations. One solution could be to construct alternate forms of written and verbally administered questionnaires that reflect the anticipated variations within the targeted group.

Gaining Access

Agencies that have information or are potentially in a good position to collect data are government agencies at the Federal, State, and local levels; civic organizations; and school systems. However, these agencies often collect general data that do not reflect the needs of specific subgroups. Such information sources may resist attempts of program evaluators to enter their domain to collect data relevant to subgroups of interest.

This resistance may reflect an adversarial view of evaluators or a sense of territoriality among some agency personnel. Gaining the cooperation of key players, especially community constituents, is crucial to data collection, and several procedures are recommended for accomplishing this.

First, the evaluator may fear that a program evaluation might embarrass existing agencies, which could have negative consequences for the long-range goal of improving services. One way to identify strengths and weaknesses is to ask these programs to serve as coevaluators and to have them provide a statement of strengths and *limitations* (not *weaknesses*).

Second, researchers should identify the community leaders and indicate how the data would help rather than hurt their communities.

Third, AOD misuse/abuse data should be collected in many different settings and on many different occasions. Because many Chinese ethnic groups still consult with Chinese doctors who practice oriental medicine for their physical and medical problems, Yen (1989) proposes that data collection should include these professionals as well as making AOD abuse prevention information available through the stores that sell herbal medicines.

Many Asian/Pacific Island Americans who suffer from AOD abuse problems, including those related to alcohol, may appear in private clinics and hospital emergency rooms. It is important to gain access to these settings as well as to traditional service agencies.

Framing Evaluation Questions

Before discussing what types of questions are useful and appropriate to the culture and its concerns, the basic process of designing an evaluation should be noted. First, the evaluators must determine the purposes of the evaluation. Second, they must identify those agencies and their components that should be involved in the process. Third, they should arrange a preliminary meeting with the potential cooperative agencies. Although these agencies may not have any expertise in the technical aspect of the evaluation process, their input regarding community needs and issues, which the evaluator might overlook, is crucial.

This group should meet periodically and serve as consultants to provide the evaluators with continuous feedback regarding the types of questions that should be asked and avoided, and the types of evaluation that are desired. If the evaluation focuses on certain subpopulations such as Chinese elders, individuals who are familiar to this population—e.g., traditional health care providers and leaders of community civic groups and religious organizations—should be invited to participate.

The framing of questions should be a community effort. This stage is perhaps the most important and most difficult of any evaluation because it requires as much political acumen as it does scientific expertise. It is inappropriate for evaluators to impose their view of the program goals or evaluation criteria. Rather, the evaluator must solicit the input of all relevant constituencies in the community to determine their concerns. In some communities, there may be a concern with alcohol; in others, with illicit drugs; and the illicit drug of most concern may vary from community to community. If the community sees that its own concerns are driving the evaluation effort, it will be more willing to participate in the research process. Moreover, when the community feels the evaluation is addressing its needs, it will be more willing to apply the results of the evaluation.

With the exception of preliminary surveys, all prevention and treatment program evaluations ideally should be designed to measure the within-client changes from pre- to postintervention. The most common mistake that occurs in both process and outcome evaluations, however, is that the data simply enumerate the activities and participants. A careful review of the currently available information on Asian/Pacific Island-American AOD abuse prevention programs reveals a similar deficiency. However, pre- and postintervention data-collection techniques in prevention programs are not limited to those that directly measure participant variables. Data may include pre-post surveys of local school, church, and community organizations' perceptions of the problem; pre-post local police data regarding AOD abuse-related arrests and calls; and similar examination of pre-post local hospital emergency room admissions data.

Data may also include less direct measures. Pre-post data on participation in prosocial activities such as organized sports, church activities, and anti-AOD abuse groups by members of the targeted population may provide supportive evidence of program efficacy. As Bloom and Fischer (1982) note, this is the age of accountability, especially for the human service professions. Scarce resources and numerous options for spending funding make evaluation more important than ever.

Implications for Social/Public Policy: Potential Negative Implications

Posavac and Carey (1980) point out the potential negative implications of any evaluation. First, there could be overgeneralization from an inadequate sample. As many of the AOD abuse treatment and prevention programs designed for Asian ethnic groups have relatively small sample sizes, evaluations for Asian/Pacific Island Americans are perhaps more likely to suffer from this type of problem. Overgeneralization can lead to inappropriate conclusions—e.g., that there is no AOD use when the sample is not large enough to detect a low level of use, or that programs do not work when the sample is too small to detect substantial differences in their success rates.

Second, stereotyping might result from incomplete data interpretation. The most obvious example is that Chinese-American youths have been stereotyped for years as model youths without any psychological problems. Only in recent years, with the emergence of the Chinese youth gang problems, has there been a change from a totally positive stereotype to an almost totally negative one.

Because Asian/Pacific Island Americans have been labeled as having fewer drug problems compared with other ethnic groups, there are fewer specialized programs designed to meet their needs. Yet stereotypes also can lead to their exclusion from the mainstream of society, the logic being that, if they have their own problems, they should have their own programs. To some extent, then, Asian/Pacific Island Americans are excluded not only from the mainstream of our society but from the addicted population as well.

The point here is certainly not to advocate that specialized AOD misuse/abuse prevention and treatment programs for different ethnic/racial groups should be reduced; it is simply to point out the potential negative implications of stereotyping. Negative consequences perhaps can be avoided by creating special programs and, at the same time, decreasing barriers to Asian/Pacific Island-American participation in mainstream and multiethnic programs.

Implications for Social/Public Policy: Potential Positive Implications

Davis (1990) notes that the proper use of evaluation results may bring us closer to new solutions that can reduce or eliminate the AOD abuse problem, affect funding levels, highlight the linkages between problem behavior precursors and contributing factors, contribute to decisionmaking creativity, and facilitate program growth. Moreover, evaluation can detect the problems associated with changing populations and help find alternatives that are important to the community.

Demone (1974) stresses how people can influence policymaking. In the needs assessment, data provide them with the information they need to convince policymakers of the worth of their suggestions.

At the program development level, Posavac and Carey (1980, p. 11) believe there are six important reasons for program evaluation: fulfillment of accreditation requirements, accounting for funds, answering requests for information, making administrative decisions, assisting staff in program development, and learning about unintended effects of programs. With Asian/Pacific Island-American communities, successful AOD prevention and treatment program evaluation will have additional benefits: It will provide a baseline to better establish human services needs, permit better services to the population, and help the community use currently available resources more effectively.

In summary, then, the key issues in the use of evaluation results are how to overcome the attitude that identifying problems is always bad and how to use the results more constructively.

The Art of Becoming a Culturally Competent Evaluator

There are many requirements that facilitate an evaluator's becoming culturally competent. First, an evaluator must be aware that communities are always changing and that Asian/Pacific Island-American communities are no exception. The evaluator must be sensitive to this complicated change process.

During the past two decades, immigrants from different Asian ethnic groups have entered this country at diverse educational, occupational, and economic levels as well as with diverse value and belief systems. Other important differences include the family structure: The stereotype that all Asian/Pacific Island Americans have highly structured families is no longer true, if it ever was. Differences among age groups also may affect this population's AOD use behavior, yet understanding of AOD abuse patterns among elders, and especially among Asian/Pacific Island Americans, has long been ignored.

To establish the evaluator's credibility in the community is not an easy task. Community leaders and program staff should be involved in the process from the very beginning. The process is not a one-time event; an evaluator must continuously make him- or herself known to the community by participating in nonprogram-related community events. To a great extent, this means greater responsibilities than are usually undertaken by an evaluator/consultant, but this is necessary when dealing with special populations.

In identifying questions that are useful and appropriate to the culture and concerns of the ethnic communities, evaluators must realize that there are many different Asian/Pacific Island-American ethnic groups, each with its own culture and taboos. This is why a preliminary input group is needed.

Researchers should also be aware of language-related issues. First-generation Asian immigrants, regardless of age, education, or professional status, are extremely sensitive about their verbal communication skills. As Lee (1986) notes, Asians usually have difficulty discussing their problems or expressing themselves emotionally in an alien tongue. Questions should be formulated using the culturally appropriate terminology. For example, for the Chinese ethnic group, the word *Ju* (alcohol) actually includes all types of alcoholic beverages, which may lead to confusion.

Although bilingual ability is desirable, it is difficult to find evaluators who speak all relevant dialects and have the necessary scientific training. However, consultation with informants is an effective substitute for bilingualism.

Although each Asian ethnic group is unique, they have some differences in common relative to Caucasian populations. The researcher would do well to take these differences into account.

- Because Asians generally drink with their friends and in recreational settings, questions about the antecedents of their drinking usually can provide the clues for potential AOD use and abuse. It is important to understand the social contexts of AOD use, especially in determining what types of interventions will be most efficacious.
- In contrast with other mental health practitioners, this author strongly recommends avoiding issues related to

discrimination in the content of the evaluation. No doubt many Asian ethnic groups have suffered discrimination, as have other ethnic/racial groups, but this topic is usually taboo in discussions with outsiders.

- Questions regarding sexual topics should be regarded as highly sensitive. Even though AOD misuse/abuse prevention workers are concerned with sexual activities in relation to acquired immunodeficiency syndrome, Asian communities still consider such questions too personal to be discussed in public.

The line between what is necessary versus what is sufficient for becoming a culturally competent evaluator is a very thin one. To a great degree, the criteria for becoming a culturally competent evaluator for Asian/Pacific Island-American ethnic groups are perhaps not significantly different from those for becoming a culturally competent evaluator for any other cultural group. In essence, a competent evaluator should work to gain the confidence of the community and to convince it of the benefits of adequate evaluation. In doing so, the evaluator must strive to exhibit a level of cultural sensitivity commensurate with his or her level of evaluative expertise.

Ideally, the culturally competent evaluator will also be actively involved with planning-related tasks. This means that the evaluator should enter the process at the inception of an AOD prevention program, rather than after the program has already been implemented. Also, it is desirable that the results of the evaluation lead to new program developments that benefit the community.

Davis (1990, p. 12) also notes that the different perspectives of the evaluators and program administrators can potentially retard the evaluation process. Evaluators are sometimes seen as auditors or monitors rather than as colleagues. As Posavac and Carey (1985, p. 23) note, there are two types of evaluators, the external consultant and the in-house evaluator. Regardless of which type a program uses, the evaluators themselves must be aware of the problems they are facing. In the Asian/Pacific Island-American communities and programs, the traditional fear of losing face (shame) if a program does not succeed will make the task of program evaluation even more difficult.

The real challenge for a culturally competent evaluator is to discover new procedures for collecting data away from the program setting. Aside from the cultural variables, it is also necessary for the evaluators to note that existing AOD abuse evaluation instruments may not be appropriate for evaluating the Asian/Pacific Island-American population. To provide adequate data collection, it may be necessary for the evaluator either to develop new instruments or to train paraprofessionals from within the community.

The evaluator will have to spend more time doing the legwork of gaining entry to schools, clubs, and community organizations; of talking to people in the community; and of gaining the trust of the community. This can only be accomplished by demonstrating a knowledge of the ways of the people being served and a willingness to continue that learning process.

Conclusion

Program evaluation itself offers the professional in the AOD abuse field quite a challenge. The professional who chooses to perform prevention program evaluation within the Asian/Pacific Island-American community is doubly challenged. The paucity of published research, the relative lack of appropriate formal instruments, and the monumental work of understanding a new culture with all its inherent nuances all contribute to this challenge. It is hoped that the material presented here will assist those who have accepted the challenge and encourage others to follow.

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Defining Cultural Competence: An Organizing Framework

Mario A. Orlandi, Ph.D., M.P.H.

Introduction

This final chapter has two main objectives: first, to underscore some of the monograph's highlights and common themes, and second, to offer some additional thoughts on the meaning of cultural competence. The authors who addressed the common issues of cultural competence and program evaluation competence for African Americans, Hispanics, American Indians/Alaska Natives, and Asian/Pacific Island Americans obviously approached their task in very different ways. Nonetheless, a number of common themes and principles can be extracted from this work that, we hope, will contribute to our understanding of the issues that were the focus of this publication.

Principle 1: The Need for Demystification

The entire issue of culture and its relationship to program evaluation needs to be demystified—i.e., to be brought out into the light of day and submitted to the same kind of rigorous problem solving and strategic planning that other areas related to ethnicity and race have received. It needs to be addressed by a collaboration of qualified professionals, those who are members of ethnic/racial groups and those who are not. To imply that this issue is somehow beyond such analysis is, at best, nonproductive.

Principle 2: The Need for Consensus Regarding Terminology

Consensus has not been reached on a number of significant terms that are currently being used in this area. For example, the general population can no longer be accurately dichotomized as "minority" and "nonminority," and some ethnic/racial individuals in fact consider these terms entirely inappropriate, if not offensive. It is important that individuals working and collaborating in this area continue to strive for such consensus so that communication among and between cultural scholars can be optimally productive.

Principle 3: Changing Knowledge and Attitudes Will Be Easier

The process of sharing information, an excellent example of which is this monograph itself, is straightforward and should be aggressively pursued. Similarly, the position argued in this monograph—that common ground needs to be found between those holding differing views in this area—is well defended and will likely lead to more positive attitudes.

Principle 4: Changing Value Systems and World Views Will Be More Difficult

If the fundamental deductive principles on which program evaluation methodology is based are not valued or are even deemed meaningless by someone from a particular cultural background, the process of finding some common area of agreement in this scientific arena will certainly require creative, if not truly artistic, approaches.

Principle 5: The Ambiguity of a Funding Agency's Role

Issues such as community ownership and shared decisionmaking become somewhat clouded when a funding agency's agenda becomes known. Even if the funding agency maintains an officially neutral position on a particular evaluation issue, or on all such issues, the potential for the evaluation process to be influenced by perceptions of the agency's agenda is great. When this happens, the validity of the evaluation planning process, cultural competence notwithstanding, should be brought into question.

Principle 6: The Importance of Getting Ethnic/Racial People Involved

Every aspect of the cross-cultural evaluation process—including planning, implementation, and analysis—would be improved if more ethnic/racial individuals were involved, whether formally trained in evaluation or not. Equipped with appropriate training, however, such individuals would be in a position to make outstanding contributions.

Principle 7: The Need To Distinguish Between Cultural Identification and the Culture of Poverty

It is very important to distinguish between the culture of the underclass in our society (Mincy et. al. 1990) and the culture of ethnic/racial subgroups. The experience of being poor in our society is different, for example, from that of being Hispanic, and these conditions must be further distinguished from the experience of being both poor *and* Hispanic.

Principle 8: The Need To Distinguish Between Important Within-Culture Subgroups

The four broad ethnic/racial categories used to subdivide this monograph, as well as most demographic research carried out in this country, mask important differences between some subgroups that are subsumed under these headings.

Principle 9: The Need To Promote Consumer Skills and Values Within the Community With Respect to Evaluations

If the sort of technology transfer that is envisioned in this monograph is going to take place, it will require that communities accept some of the responsibility for becoming more effective consumers of evaluations. Total reliance on external expertise for any aspect of the evaluation process will hinder the process of empowerment.

Principle 10: The Importance of Going Beyond Cultural Competence

While agreeing that there are specific skills that can be learned through training—either in formal programs or in on-the-job training—the authors of this monograph definitely convey the sense that there is also something more to which program evaluators should aspire. For example, would an individual who has just completed his or her training program be fully prepared for the challenges of a cross-cultural evaluation setting? Possibly not, and the differences between such an individual and a more seasoned, bicompetent professional in such a setting are what motivated the discussion that follows.

Beyond Cultural Competence: The Cultural Sophistication Matrix

Based on a review of the operational definition of cultural competence put forth in chapter 1 and on the various ways in which the term has been used throughout this monograph, two things become obvious: First, this is a concept that is clearly multidimensional, involving various aspects of knowledge, attitude, and skill development; second, these relevant aspects vary along a continuum from high to low. A schematic representation and organizing framework for these features was sought to make these complex relationships more understandable. The result is a 4 by 3 matrix in which the rows depict different aspects of cultural competence and the columns reflect the continuum from high to low (see fig. 7). A similar, unidimensional representation of this continuum concept has been formulated by the Child and Adolescent Service System Program to address issues related to effective services for emotionally disturbed children (Cross et al. 1989).

	Culturally incompetent	**Culturally sensitive**	**Culturally competent**
Cognitive dimension	Oblivious	Aware	Knowledgable
Affective dimension	Apathetic	Sympathetic	Committed to change
Skills dimension	Unskilled	Lacking some skills	Highly skilled
Overall effect	Destructive	Neutral	Constructive

Figure 7. The Cultural Sophistication Framework

In conceptualizing the rows of the matrix, it is useful to think in terms of cognitive development, affective development, and skills development because these are typical objectives of competence training programs in other disciplines (Fullan and

Pomfret 1977). In addition, a fourth factor, overall effect, provides a means of estimating a type of composite rating that sums across the other factors.

The continuum ranges along the columns of the matrix from culturally incompetent to culturally competent with one intermediate category, culturally sensitive. The characterizations suggested by the cells of the matrix provide some useful distinctions. For example, the intermediate category can be thought of as describing someone who is aware of the issues involved and is sympathetic to the needs created by the particular cultural problem in question, but who lacks the necessary skills to do anything about it. At best, the overall effect of such a person is likely to be neutral.

This would certainly be preferable to being oblivious to the problem, apathetic, or antagonistic, and utterly lacking in the requisite skills; the overall effect of this could be destructive. Neither of these descriptions, however, would be as culturally desirable as that of someone who fully understands the issues involved, is fully committed to change, and is highly skilled in the areas needed. This is, perhaps, a more meaningful definition of a culturally competent person than that offered in chapter 1.

The term *cultural sophistication* was selected to describe the multidimensional characterization as a whole. Besides simply characterizing three stereotypes, this sort of approach allows for individual assessment along each of the dimensions independently; in other words, an individual could be highly knowledgeable and fully committed to change but completely lacking in the requisite skills. This approach to cultural assessment would have obvious practical implications for the evaluation of training programs in this area.

Concluding Thoughts

It is always clear that a volume such as this can never, by itself, produce the changes it has called for. It may, at best, serve as a catalyst for change by heightening awareness, enhancing motivations to take action, and providing some clear recommendations for doing so. The editors and authors sincerely hope that these more modest objectives have been met and that our readers more clearly appreciate the concept of, and the need for, culturally competent program evaluation as the result.

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